

NOAH SMERNOFF: A LIFE IN MEDICINE

Interviewee: Noah Smernoff

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Description

Noah Smernoff: A Life in Medicine is the initial volume in an oral history series launched with the support of the Great Basin History of Medicine division of the University of Nevada School of Medicine.

Noah Smernoff was born in Denver on the last day of December, 1904, the son of Russian immigrants. His father, a tailor, struggled financially to raise eight children, and Noah sold newspapers and had a number of jobs through high school to help support the family. His parents emphasized the value of an education and urged all of their children to go on to college. Noah blossomed into a top student in chemistry at the University of Denver. From there he went on to the new Denver General Hospital and Medical School, and graduated in 1928.

Dr. Smernoff did his internship in Salt Lake City in 1928-1929. While there he was introduced to industrial medicine during a one-month relief assignment at the Bingham Canyon Hospital, a facility serving five underground mines in Bingham Canyon. This experience was the prelude to twenty-three years of industrial medicine.

The heart of Noah Smernoff: A Life in Medicine is an account of Dr. Smernoff's practice in the mining communities of White Pine County, Nevada, from 1929 to 1953. At that time the Ely district was the second largest population center in Nevada, next to Reno. Medicine and health care, politics, segregation, prejudices, injustice, and the people of the mines are all described. Dr. Smernoff discusses the departure of the Japanese from Ely during World War II; the communities of Steptoe, Ragtown, Greek Town, Austrian Town; the necessity for legalized prostitution; and so on.

In 1953, Noah, his wife Josephine, and their two children, Susan and Ann, left White Pine County and came to Reno. They arrived during the great polio epidemic, and he was enlisted into the fight against the disease in Washoe County. Shortly after arriving in Reno, Dr. Smernoff started what became the Ralston Medical Clinic, still one of the leading clinics in the community. In 1978, he retired at the age of seventy-four, but for years one would still see him visiting his patients in the Reno hospitals.

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GREAT BASIN MEDICAL HISTORY DIVISION DEPARTMENT OF PATHOLOGY
UNIVERSITY OF NEVADA SCHOOL OF MEDICINE

An Oral History Conducted by and Edited by R. T. King

University of Nevada Oral History Program

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PREFACE TO THE DIGITAL EDITION

Established in 1964, the University of Nevada Oral History Program (UNOHP) explores the remembered past through rigorous oral history interviewing, creating a record for present and future researchers. The program's collection of primary source oral histories is an important body of information about significant events, people, places, and activities in twentieth and twenty-first century Nevada and the West.

The UNOHP wishes to make the information in its oral histories accessible to a broad range of patrons. To achieve this goal, its transcripts must speak with an intelligible voice. However, no type font contains symbols for physical gestures and vocal modulations which are integral parts of verbal communication. When human speech is represented in print, stripped of these signals, the result can be a morass of seemingly tangled syntax and incomplete sentences—totally verbatim transcripts sometimes verge on incoherence. Therefore, this transcript has been lightly edited.

While taking great pains not to alter meaning in any way, the editor may have removed false starts, redundancies, and the “uhs,” “ahs,” and other noises with which speech is often liberally sprinkled; compressed some passages which, in unaltered form, misrepresent the chronicler's meaning; and relocated some material to place information in its intended context. Laughter is represented with [laughter] at the end of a sentence in which it occurs, and ellipses are used to indicate that a statement has been interrupted or is incomplete...or that there is a pause for dramatic effect.

As with all of our oral histories, while we can vouch for the authenticity of the interviews in the UNOHP collection, we advise readers to keep in mind that these are remembered pasts, and we do not claim that the recollections are entirely free of error. We can state, however, that the transcripts accurately reflect the oral history recordings on which they were based. Accordingly, each transcript should be approached with the

same prudence that the intelligent reader exercises when consulting government records, newspaper accounts, diaries, and other sources of historical information. All statements made here constitute the remembrance or opinions of the individuals who were interviewed, and not the opinions of the UNOHP.

In order to standardize the design of all UNOHP transcripts for the online database, most have been reformatted, a process that was completed in 2012. This document may therefore differ in appearance and pagination from earlier printed versions. Rather than compile entirely new indexes for each volume, the UNOHP has made each transcript fully searchable electronically. If a previous version of this volume existed, its original index has been appended to this document for reference only. A link to the entire catalog can be found online at <http://oralhistory.unr.edu/>.

For more information on the UNOHP or any of its publications, please contact the University of Nevada Oral History Program at Mail Stop 0324, University of Nevada, Reno, NV, 89557-0324 or by calling 775/784-6932.

Alicia Barber
Director, UNOHP
July 2012

ORIGINAL PREFACE

Since 1965 the University of Nevada Oral History Program (UNOHP) has produced over 200 works similar to the one at hand. Following the precedent established by Allan Nevins at Columbia University in 1948 (and perpetuated since by academic programs such as ours throughout the English-speaking world) these manuscripts are called oral histories. Unfortunately, some confusion surrounds the meaning of the term. To the extent that these 'oral' histories can be read, they are not oral, and while they are useful historical sources, they are not themselves history. Still, custom is a powerful force; historical and cultural records that originate in tape-recorded interviews are almost uniformly labeled 'oral histories', and our program follows that usage.

Among oral history programs, differences abound in the way information is collected, processed and presented. At one end of a spectrum are some that claim to find scholarly value in interviews which more closely resemble spontaneous encounters than they do organized efforts to collect

information. For those programs, any preparation is too much. The interviewer operates the recording equipment and serves as the immediate audience, but does not actively participate beyond encouraging the chronicler to keep talking. Serendipity is the principal determinant of the historical worth of information thus collected.

The University of Nevada's program strives to be considerably more rigorous in selecting chroniclers, and in preparing for and focussing interviews. When done by the UNOHP, these firsthand accounts are meant to serve the function of primary source documents, as valuable in the process of historiography as the written records with which historians customarily work. However, while the properly conducted oral history is a reliable source, verifying the accuracy of all of the statements made in the course of an interview would require more time and money than the UNOHP's operating budget permits. The program can vouch that the statements were made, and that the chronicler has approved the edited manuscript, but it

does not assert that all are entirely free of error. Accordingly, our oral histories should be approached with the same caution that the prudent reader exercises when consulting government records, newspaper accounts, diaries and other sources of historical information.

Each finished manuscript is the product of a collaboration—its structure influenced by the directed questioning of an informed, well-prepared interviewer, and its articulation refined through editing. While the words in this published oral history are essentially those of Dr. Smernoff, the text is not a *verbatim* transcription of the interview as it occurred. In producing a manuscript, it is the practice of the UNOHP to employ the language of the chronicler, but to edit for clarity and readability. By shifting text when necessary, by polishing syntax, and by deleting or subsuming the questions of the interviewer, a first-person narrative with chronological and topical order is created. Dr. Smernoff has reviewed the finished manuscript of his oral history and affirmed in writing that it is an accurate representation of his statements.

The UNOHP realizes that there will be some researchers who prefer to take their oral history straight, without the editing that was necessary to produce this text; they are directed to the tape recording. Copies of all or part of this work and the tapes from which it is derived are available from:

The University of Nevada
Oral History Program
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INTRODUCTION

One can not study medicine or stay abreast of advances in medical care without understanding its history, which includes not only the great discoveries of research physicians such as Jonas E. Salk, who helped eliminate polio, but also the experiences of doctors who served on the front lines of medicine. The practice of medicine in early Nevada has been recorded only infrequently in newspaper articles, and occasionally in works such as *The Journals of Alfred Doten* or *Sagebrush Doctors*, a description of the formation of the Elko Clinic by local historian Edna B. Patterson. To my knowledge, no concerted effort has been made to describe comprehensively the practice of medicine and the daily life of doctors in Nevada, from early times to the present. With this goal in mind, the Great Basin History of Medicine division (GBHM) of the University of Nevada School of Medicine was established in 1989 by the department of pathology, with the help of scholars from the university's oral history program and department of history.

Among various activities that the GBHM supports are the efforts of history professors

Bruce Moran and Martha Hildreth to organize seminars and conferences for the presentation of research papers on the history of various fields of medicine in our region. In addition, a quarterly bulletin, *Greasewood Tablettes*, has been started by Owen C. Bolstad, M.D., to provide for the periodical publication of items of current and historical information. However, realizing that physicians who practiced in Nevada in the first half of the twentieth century are a limited and dwindling resource, our first priority was to launch an oral history series focusing on doctors who practiced in the state prior to World War II. *Noah Smernoff: A Life in Medicine* is the initial volume in this series.

Noah Smernoff was born in Denver on the last day of December, 1904, the son of Russian immigrants. His father, a tailor, struggled financially to raise eight children, and Noah sold newspapers and had a number of jobs through high school to help support the family. By his own account, Noah was an average student because he was too busy doing the things boys do, but he was interested in

academics and he read extensively. His parents emphasized the value of an education and urged all of their children to go on to college. Motivated by a desire not to become “some kind of day laborer,” Noah blossomed into a top student in chemistry at the University of Denver. In 1924 his older brother, Meyer, and his Uncle Louis encouraged him to apply for admission to the new Denver General Hospital and Medical School a few blocks from the Smernoff residence. Noah was accepted, and the money he earned at summer jobs, plus the opportunity to live at home and walk to school, made his medical education affordable.

Dr. Smernoff did his internship in Salt Lake City in 1928-1929. While there he was introduced to industrial medicine during a one-month relief assignment at the Bingham Canyon Hospital, a facility serving five underground mines in Bingham Canyon. The mines attracted violent men, and Dr. Smernoff was advised to carry a gun. He refused, of course, and treated all individuals equally as patients. This experience was the prelude to twenty-three years in industrial medicine.

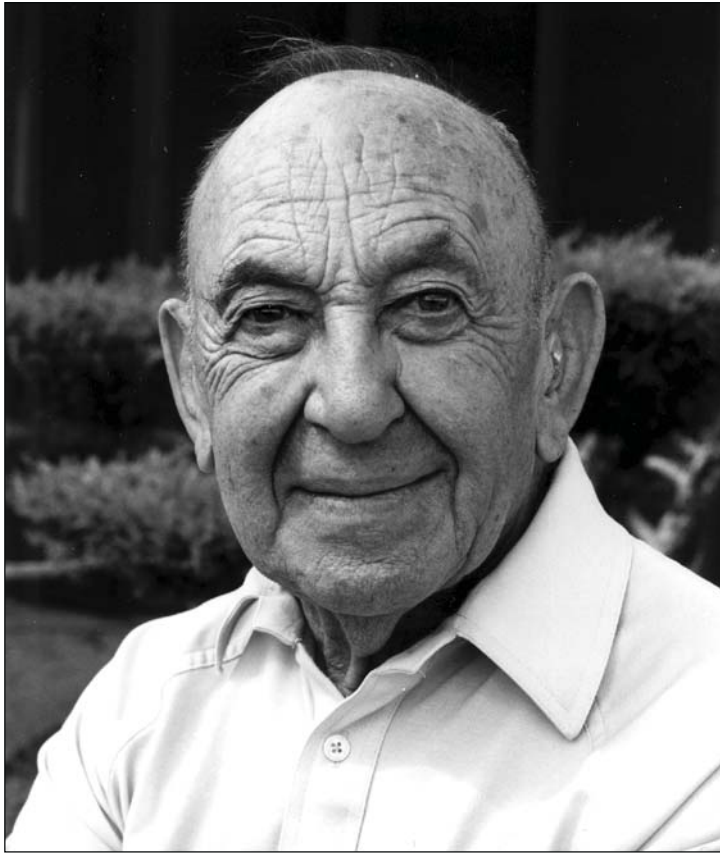
The heart of *Noah Smernoff: A Life in Medicine* is an account of Dr. Smernoff’s practice in the mining communities of White Pine County, Nevada, from 1929 to 1953. The reader’s view through this one small window in time is incredible. Medicine and health care, politics, segregation, prejudices, injustice, and the people (family) of the mines are all described. You will laugh and cry. Imagine one of Dr. Smernoff’s “patients,” a bull, “exploding” while undergoing an operation on an eye. You will see the Japanese being loaded into buses during World War II, never to return to Ely. There is much more—Steptoe, Ragtown, Greek Town, Austrian Town, the necessity for legalized prostitution, and so on. At that time the Ely district was the second largest population center in Nevada,

next to Reno. Noah knew, and remembers in these pages, some of the leading politicians of the time: Senators Pittman and McCarran, Representative Baring, and Governor Russell.

In 1953, Noah, his wife Josephine and their two children, Susan and Ann, abruptly left White Pine County and came to Reno. They arrived during the great polio epidemic, and he was enlisted into the fight against the disease in Washoe County. The practice of medicine at that time is hard to imagine for those who have never seen a polio epidemic. Shortly after arriving in Reno, Dr. Smernoff started what became the Ralston Medical Clinic, still one of the leading clinics in the community. In 1978, he retired at the age of seventy-four, but for years one would still see him visiting his patients in the Reno hospitals. I am certain that if today Dr. Smernoff learns that one of his former patients is hospitalized, he will make rounds and visit.

Dr. Smernoff is a man who has given his life to his patients, and in this volume the very soul and essence of his motivations are revealed. He has quietly led an exemplary life without fanfare, but he has touched and inspired the lives of thousands. After reading his recollections, one feels like young Luke, who carries Dr. Kellogg’s bag in *Not as a Stranger* and subsequently follows his example to become a doctor. Dr. Noah Smernoff is a role model for all those who aspire to medicine as a career. However, this oral history was recorded and is being published not only for medical doctors and students, but for all who are interested in how medicine was practiced and life lived in eastern Nevada mining towns before World War II.

Anton P. Sohn, M.D.
Chairman, Department of Pathology
University of Nevada School of Medicine



NOAH SMERNOFF, 1990

Photograph by R. T. King

GROWING UP IN DENVER

All my grandparents were citizens of the Russian city of Odessa. Grandfather Smernoff was a contractor who did a lot of building in the city. My father was born in Odessa in March, 1868, and he emigrated to the United States when he was eleven years old, coming in a sailing boat, which took about three months. His parents were looking to the future, knowing that if they didn't get him out of the country, he would eventually end up in the Russian army. They decided they better send him over to live with relatives in the United States who were already here. Father used to tell me that his first work was in a saloon in New Haven for a relative.

My mother was a first cousin of my father's. She was born in November of 1875, and came to the United States with her mother when she was two years old. They settled in New Haven. My parents were married in 1898, and they proceeded to have children about every year. My oldest sister was born in 1899; my oldest brother in 1900; and other brothers in 1901 and 1903. My mother was pregnant with me in 1904 when my parents moved to Denver to

be near two sisters of hers and a sister of my father's who had moved there several years before. My maternal grandfather apparently had died in Russia before the family came over, but my grandmother did come to the United States with my mother, and she also moved to Denver and lived with us and with the family of one of my aunts until she died. She was an excellent cook, who, of course, insisted that if you were sick, chicken soup was the *only* thing to give you. [laughter]

I was born in Denver on December 31, 1904, in a slum area, which was the only neighborhood my parents could afford at that time, having four other children. I was the fifth child of the family. At that time they said every fifth child born in the world was Chinese; and I used to say that I must have been the Chinese child! [laughter]

Father had learned the tailoring trade, and, although he was illiterate (the only thing he could write was his name), he eventually became one of the best women's clothes designers in Denver. He went into business

with a man by the name of Marx, who was a men's tailor. He and Marx ran their store as a loose partnership. Their customers included the governor and his wife, the mayor and his wife, the judges and their wives...and this went on for years. As a child, I remember meeting all of these people at the store when we would go down. There were four seasons in the clothing business. The spring was a good season; we had money then. Then the summer was a dead season; we owed everybody in town. Then fall came along and Dad made enough to pay off all the bills, and winter came, and we went back in debt. It was an up-and-down existence all my life there in Denver with good times in the spring and fall, and lean times in the summer and winter, because that was the way the business was.

Father never had any schooling at all, but he was a terrific man—a great father, a great husband, a great businessman, and just a real idol for us children. Our first house was down where the houses of ill repute and the saloons were, in the really depressed area, but when I was three years old, my father bought a home out in east Denver, which was a new area that was just starting. There were only two big houses, and in a three-fourths-of-a-mile radius there were no other houses. We did have electricity and we had a telephone; but no streets, no curbs, no sidewalks. It was a beautiful house, but being out in that area, the family had enough to pay a deposit on it. I lived to watch all of the streets and curbs and sidewalks and the houses built there; it was a great time for a child.

We children didn't work in my father's tailor shop. That took too much training, and none of us went into that. But I started selling newspapers when I was four years old on Sunday mornings at a Catholic church. My

brothers were doing it, so I went along with them, and that was a great thing. (My family says that as I tell this story, it finally gets down to where I was selling papers at six months of age [laughter] which they *know* is not correct.) I did that for a couple of years; then, when I got to be about eight or nine years old, I would deliver prescriptions for the corner drugstore for a nickel or dime at a time, spending a couple of hours a day walking around the neighborhood. Eventually I was able to get a second-hand bike, and I developed a newspaper route in downtown Denver. I used to deliver what was then the *Denver Express*, an afternoon paper, to the cigar stores and the drugstores. I think we got a penny a paper for delivering them. I would probably deliver about sixty a day.

By the time I was thirteen, I was working as a hopper...that is, a boy who rides along with a driver and takes the packages from the truck to the house. I did that on Saturdays for a driver out of the Denver Dry Goods store. That paid about two dollars a day, and I worked on Saturdays during the school year and six days a week during the summer. Then I went on to work as a hopper delivering groceries after school and on Saturdays. The truck drivers would teach you how to drive, and I had a lot of contacts. Then a brother of mine became a clerk at the grocery store, and he would drive a truck intermittently and he helped teach me. But by the time I was fifteen, I was able to get a driver's license and was driving a delivery...well, it was a big Studebaker car.

The boss's son had a Stutz-Bearcat that I used to drive out to the ranch for him. It was about twelve or fifteen miles away, and I would take groceries out for that ranch. I loved driving that Stutz-Bearcat! In fact after I got a little older, Mr. Cox let me drive it in a couple of races. I never won anything, but

I used to be able to kick it up to sixty miles an hour on the two-mile oval dirt track at Overland Park. I just loved that—that was really something. My parents did not know about this until it was over, and they weren't much for it. The cash prizes were minimal; it was only a routine weekend racetrack thing.

When I was sixteen, a florist who had the store next to my father's in the downtown area of Denver gave me a job delivering flowers on my bicycle, so I did that all summer. After that summer, I got a job at a drugstore where I would work after school and Saturdays. On Sundays I'd go down to the store at six o'clock in the morning and mop the floor and clean it up a little bit. Then I would come back after Sunday school and work until ten o'clock and lock the store up. We all worked and put our earnings in the family pot for haircuts and shoe repairs and groceries. All earnings went into the family pot, but once in a while we'd go to a show and have a candy bar or something like that. When I was a youngster, there would be five of us kids go to the show. We four boys would make our little sister walk behind us so people wouldn't know she was with us. [laughter] Dad would give us thirty cents—a nickel apiece for the movie, which was all it cost, and each of us would have a penny's worth of candy.

There were eight of us children in the family; the oldest and the youngest were girls, and the six in between were boys. We lost one of the boys when he was two-and-a-half years old, shortly after I was born. I myself had scarlet fever when I was four-and-a-half, and they put me in the hospital. They didn't expect me to live. I developed a mastoid and hemorrhagic nephritis. I spent about six weeks in the communicable disease hospital in Denver that they called the pest house, and finally got well enough to come home.

I really have had fairly good health all my life since then, but I guess that laid me low, because they wouldn't let me do anything for a long time. My hearing was damaged by the infection, but I don't think that set me back any. In fact I played football, and at the University of Denver I wrestled on the wrestling team. I also headed up their gym circus my sophomore year. Physically, I've been great.

We were a close-knit family. We would have picnics up in the mountains or out at one of the lakes in Denver whenever the weather was good. We went as a family unit, and usually there were our two other aunts and their families. They all had children, so that we had a good time. In the wintertime we would have our Sundays together at one or the other's home—have dinner and play cards, fight, and do all the things that kids do. Most of our entertainment was with family. The get-togethers were great things. Some of the family played piano, some played violin, and we would have sing-a-longs and quite a lot of music. Of course, we played cards, played a lot of bridge and whist and things like that; but otherwise there was just the comradeship of the group.

As a kid I loved the out-of-doors. We had a neighbor, my best friend, with whom I went to school and later to medical school. His family had a cabin in the mountains out of Bear Creek up above Lookout Mountain. Through the summer I would spend five or six weekends up there. It was a lot of fun. We would hunt cottontails and hike the mountains. I loved hiking in the mountains. In town, very often I would just take off on my own and walk downtown from where we lived, which was about two-and-a-half miles. Walk down and walk back, just for myself. I liked the solitude of it, to get away from everybody and everything.

I was in an age group that missed kindergarten for some reason or other. I was either too young to go in one class or too old to go into the other, so I started in the first grade at a school called the Columbine School, which was about eight blocks from home. I had two brothers and a sister going there, so Mother never did take me, but my brothers and sisters got me signed in. Shortly after I started there, the Aaron Gove School further to the east of us opened, and they transferred all of us to it. I went there from the first through the sixth grade. Then they changed it to a junior high school and I went there the seventh, eighth and ninth grades.

Mother had a high school education, and she prepared us well. We kids could read and write before we started in elementary school, and we were as well prepared as other children at that time. I got along pretty well, but I guess I was a real aggressive kid, because I was always getting in fights, and most of the time losing them. I think that having two older brothers at school made me more aggressive, because I knew they'd protect me. At one time, five Smernoffs were going to the same school, and nobody picked on a Smernoff without getting in a big fight, and nobody ever won that fight. [laughter] We fought like cats and dogs at home, but when it came to a family of children who stuck together, we did that very nicely.

My family were Jewish, but as a boy I never experienced any prejudice or any problems because of that, and I never encountered any such problems in my life. We went to synagogue on a regular basis, and at one time I went to a Sunday school at which I learned to read and write Hebrew. I eventually lost all facility in Hebrew, as I haven't used it in sixty or seventy years.

I was an average student, but I passed all of my courses, and after leaving junior

high, I went to East Denver High School. At this time I was interested in athletics, and I thought that I would like to play football. I finally lettered, earning my 'E' in my senior year, weighing 106 pounds and playing end. I did not play in every game, but I played enough to letter. At that time, when you played end, you were both offensive and defensive. There was no such thing as a two-squad team. You just played wherever they put you, and I took a real beating, because the average weight of a high school player at that time was about 150 pounds. But it was a good experience.

I recall one bad part of my education concerned Latin. I had taken a year of Latin, and the second year I went to class for six weeks during which I never grasped the lesson. I can still remember Dr. Pitts telling me that I would never do any good, and that I may as well go down and change my course of subjects. But instead of doing that, I just didn't go to class any more. I would spend the scheduled hour over at the drugstore on the corner visiting with people who came in, and made a very nice thing of it. However, I liked German, and I took three years of German and was able to speak it and read scientific articles and translate them...but the Latin was too deep for me.

At the time that I was going to high school, we needed sixteen credit hours to graduate. You had to have four solids every year for four years, and I picked up enough extra credits so that I only had to go to high school half a day in my senior year. I did pretty well academically, but I wasn't on the honor roll or anything like that, because I had other activities. However, I always read at home a lot. After everybody was bedded down at the house, I would be reading something. My favorite literature was detective stories, and I liked historical novels and biographies.

My mother and father had no particular ambitions for us children when we were young. They just wanted us to get an education and go to college and decide what we wanted to do. I think they were dead set on that mostly because my father had had no chance. My mother had a high school diploma, and she would have loved to go on and teach, but, of course, she got married and had eight children, so that put that on hold for her. But my parents were interested... they were absolutely adamant that we go to school, and felt that without an education one would end up in a pool of manual laborers. My sisters were honor students. My brothers and I were *comme ce, comme ca...* and kicked out of class occasionally, just like boys were in those days.

My brother Bernard died when he was about two-and-a-half years old. Of the seven surviving children, Eva, my oldest sister, went on to become a bookkeeper for my father in his store. Next was Milton, who became a salesman, followed by Meyer, who became a physician. I was born after Bernard; then came Hyman, who became an electrical engineer. Gerald became a chemical engineer, and the youngest of us, Edith, went on to become a schoolteacher in Denver.

After I graduated from high school I went to the University of Denver, because it was the cheapest place and I could live at home. We didn't have any money, although I'd worked enough jobs to save enough for tuition for one year at the University of Denver. I didn't get very good grades in high school, but at the university I knew that the chips were down: I either had to make it or end up as some kind of day laborer.

When I decided to go to college, I started out wanting to be a chemical engineer, and chemistry was my *love*. My first final grade

in chemistry was a ninety-eight, and when I finished the first two years I had fifty hours of chemistry with an average of about ninety-six. Dr. Gustafson, who was head of the chemistry department, would let me administer quiz sections of my peers, and I can still remember one examination when I sat in the front row in the amphitheater and wrote very large, so my friends behind me could see what I was writing. Dr. Gustafson called me into his office and said, "You know, Noah, that's just as much cheating as if you copied it from the other men." I stopped after that, but these people were real good friends of mine, and I wanted to see them get by, and I didn't really think of it as cheating. But I guess it *was* cheating, wasn't it?

I had an uncle who was a physician; another uncle was a pharmacist and owned his own drugstore and compounded beauty products as a chemist himself; a good friend was a state chemist in Colorado at the time; and probably these things had all influenced my decision to major in chemical engineering. Through my sophomore year of college, I was still thinking chemical engineering; but then my brother Meyer, who had just finished his junior year in medicine at the University of Nebraska Medical School, and my Uncle Louis, who was a surgeon in Omaha, came to Denver to visit during the summer of 1924. We were talking, and they said, "Well, why don't you become a doctor?" I admired these men so much that I thought, "Well, why not?"

In thinking of what I wanted to do with my life, I knew that I didn't want that feast and famine and up and down and owing and paying all my life. This is the way it was all through my childhood, and it was so embarrassing to have to go in and pick up your shoes that were repaired and ask the shoemaker if he would let you take them and you'd bring the money later. They were all

paid, but it was three months at a time that you couldn't do anything, and you never had any money to go in and buy anything, really. It all had to be charged. I think that influenced me to want to do something that would get me out of that way of life and would also help the family.

It was about two weeks before school was to start at the University of Colorado Medical School, but Dr. Reese, the dean of the medical school, was a family friend, so the next day I went to him and I asked if it was too late to apply for medical school. He said that this day was the last day that I could, because the admission committee met the next day. He had me go to the University of Denver and get my transcript of credits, and the transcript of East Denver High School credits, and it was a real hassle in the middle of the summer to get them. But I did get the transcripts and brought them to him that night. We turned in the application, and four days later I got a call from the admissions department that I had been admitted to medical school.

Previously, medical school in Colorado had been based on two years at the University of Colorado at Boulder, and then the last two years at the Gross Medical School in Denver. But the year before I applied they had built the new Colorado General Hospital and the new University of Colorado Medical School in Denver, and it was only about eight blocks from where I lived. Otherwise, I couldn't have cut it. I couldn't have gone to Boulder, because I couldn't have supported myself there. I had to live at home; it was the only thing I could afford.

This was the turning point in my life. When I was admitted I had stars in my eyes, and I've never lost them for medicine. It was exactly what I needed, because I just couldn't see myself sitting in an office doing office work, or even just working in the laboratory.

I couldn't just sit eight or ten hours a day and do the same thing all the time. I wanted to do things that got me out and around part of the time. It was fate or whatever you might call it that put me in the direction of medicine.

MEDICAL SCHOOL

Admission to medical school in 1924 was a far cry from what it is today. All I needed was two years of premedical work, and luckily I had taken enough biology and chemistry and language so that I was accepted. Today, you cannot get in without at least four years of premedical education, and maybe it's a good thing, because we did miss a lot of the humanities. We didn't get many of the so-called nicer things of education, like art and all of the other subjects that the children seem to have to take today, including the so-called mental improvement subjects. But we made pretty good doctors, even with what little training we had, because medical school was a real rough deal.

There were sixty-nine of us admitted, and the chairman of the admissions committee said that it was the best group that they had ever admitted. Every student had an A average from premedical training. There were only four of us from the University of Denver who were admitted at that time, and we were all, we thought, pretty good students. But we were young, and they didn't keep us busy

enough sometimes, so we got into trouble. They flunked out twenty-three of the sixty-nine in the first six weeks. A few left because they couldn't stand the anatomical dissections on the human body...but twenty-three were gone at the end of six weeks, and Dr. Wallen called us all in and told us that he had never seen such a rotten bunch of students in his whole life. But we went on, and before we graduated, the death toll was pretty severe.

Four of us from the University of Denver usually studied as a group at night there at the medical school, and we would spend hours and hours until ten or eleven or twelve o'clock, if necessary. In between time, we'd play a little penny ante poker to make a break in the routine. We were really an aggressive group. We wanted good grades, but we also wanted to learn, and we didn't cheat. We had the honor system, and cheating was very minimal among my classmates, even though the professors were never there during exams. The students went down and got the list of questions and the exam papers and brought them up, and you took an exam paper and a

list of questions and you wrote your answers and you turned it in and that was it. When someone was accused of cheating, the process was to call them before the honor board, which included professors and students. The charge was made, and if it was found to be correct then the discipline was meted out by the students with the OK of the faculty—either re-doing a course or dropping back a year in medical school. It got tough sometimes.

Tuition was so simple. Tuition my first quarter was thirty dollars plus lab fees and books, and that is the way I went through. Of course, I couldn't have gone through if tuition hadn't been so low. I just didn't make enough money.

I worked every summer, and the summer between my freshman and sophomore years, I red-capped at the Union Station in Denver, carrying bags down to and back from the trains. You had to go down a flight of stairs and then come up the incline in the tunnel, because the trains were up at a higher level. The first week there I thought my back would never be any good any more! But I eventually ended up with enough money to put myself through my sophomore and junior years. It was a real good paying job. It was entirely tips, no salary, and you bought your own uniform; but by putting in double shifts, I saved about eight hundred dollars, which was enough to put me through two years of medical school. After my junior year I took a job as the camp physician for a camp that Denver ran up in the mountains for indigent children. We used to take about forty children every week, and we would play ball with them and take them on hikes. For that, I received the munificent sum of fifty dollars a month.

When I came back to Denver, I decided I would do something for the children, so I took a boys club once a week in the Sons

of Denver program. It was under the West Colfax Viaduct, which was really a tough neighborhood. The boys were probably from fourteen to eighteen years of age; they were the kids that sold newspapers downtown, and they were really tough. They were kids that had to fight for everything they got. I had wrestled at the University of Denver, and I had worked out in the gym for two years, and I was in good physical shape. The first time that I met with this group of boys, I walked up and they looked me over, and I said, "I'm going to run this thing. If anybody has any questions about it, let's go outside and settle it right now." I only weighed about one hundred and twenty pounds, but I was just as hard as nails. They looked me over, and I guess they had talked among themselves or something, and they decided they would listen to me. I had a grand year with those boys; they were just great! I was a counselor for them, and I worked out in the gym with them.

I did not work while medical school was in session. I spent all my time in my studies. I had to, because I knew that I had to make the grade. This was my chance to get an education, and this was where I wanted to be. My family supported me with room and board, laundry, and transportation. Dad was doing fairly well by then, and we were able to do it.

Four years of medical school was a long time, but it was great. However, there was no time for a social life. I never dated anybody until I was a junior in medical school. Never took a girl out...would you believe that? I had so many things to do, and so far to go. There were women among my classmates, but not for me! [laughter] There were four women in my class, but I never went out with any of them. I had to work and I had to go to school while I could.

It was a little unusual back then to have women as medical students, and medicine for a woman in those days was a real hard vocation. The female students were probably looked down upon by a lot of the faculty; however, as classmates, we treated them the same as anyone else. The female students had a hard life in medical school, and perhaps in practice afterward. Surgery was particularly hard for women to break into, because it was a man's field, and a lot of the men resented a woman coming in to do surgery. I have a feeling that the male surgeons felt that women were incapable of doing surgery as well as a man. I don't think that they thought women had the knowledge or the ability. Surgeons were much worse than any other doctors in this particular attitude about women.

The four women in my class graduated, and two of them married classmates. One's husband became an ophthalmologist, and she also became an ophthalmologist, which was natural. Another one's husband became a surgeon, and she took up surgery—so that was a natural thing. One became a general practitioner back in one of the midwestern states.

I don't think I had any favorite courses; I liked them all, and I did well in all of them. I was interested in finding out what made people tick and what made diseases do what they did and how to treat them and how to get people well. I enjoyed all of them, but I *loved* the clinical work. When I got into my junior year and started to work in the clinics, I could have spent twenty-four hours a day in them, talking to these people and treating them. That was the thing I liked about clinical work: being with people, dealing with humans. In the laboratory, you were dealing with animals...and then you put the animal to death, so you never knew what would have

happened. You did an appendix, you did a gall bladder, you did a bypass, and then the animal was put to sleep and that was the end of it. You did acquire technical skill from it, but to be with humans—that was what I felt was the important part of medicine. I haven't changed.

Several professors were particularly influential in my education. Dr. Reese, who was a friend of the family's, was dean of the school, and was so helpful in getting me in. But the man that I loved the most was Caspar Hegner, a rough, tough doctor who was a top surgeon in Denver and who was my professor of surgery. We had good rapport, and I saw eye-to-eye with him. When he gave an examination, he didn't want a lot of chaff; he wanted just the important points. When I would take an exam from him—even a final exam, which was supposed to last two or three hours—I would be through in forty-five minutes. After my first exam he brought it up at the next class and said, "Here's what I want." He read aloud my answers to his questions, and I felt so proud! This was the way he wanted it: this and this and this! He didn't want all the chaff that didn't mean anything; he wanted answers, not dissertations.

Yet, there were other doctors who wanted the dissertation. Dr. Arndt was an internist. He wanted a composition-type answer for every question, and this is what we had to give. The short, quick cure was not for him. He wanted all of the "ands" and the "wherefores" and the "ifs," and so forth. And that is what you gave him.

We had a course in which we learned the ethical part of medicine, which was just as important as the didactic work that we had in any subject. We learned to be honest with our patients; we learned if we could not do good, don't do any harm; we learned to be considerate of our fellow doctors who might

have made a mistake, either intentionally or unintentionally. We learned to treat people as human beings, not just as medical cases, and I think that it would be well if medical schools still taught that intensively. When we graduated, we all took the Oath of Hippocrates, which still is my guide to my medical practice.

In medical school, we were given all the facets of medicine. Then, after we got out, we decided whether we were going to do eye work, ear, nose and throat, chest surgery, OB-GYN [Obstetrics-Gynecology], or anything. At the time that we went to school, we were taught to be complete doctors, including psychiatry. And when you went to a small town, you damn well better be a complete doctor, because you had no place to turn. You've got to do it. When somebody comes in with a ruptured stomach, you'd better be able to fix it, because you haven't got any place to send them. Or if an OB comes in that needs an emergency Caesarian section, you'd better be able to do it, or you're going to not only lose the child, you're going to lose the mother, too.

I came out of four years of medical school with about an eighty-seven average, which was not quite enough for AOA, the honorary medical fraternity. The reason for my low average was that in one of the physiology classes, four of us from Denver worked together in a laboratory and we got to fooling around. We never had less than a ninety, any of us, on our laboratory work or on our exams or on our finals, and yet every one of us got a D for a final grade. I had to meet with Dr. Reese, who was a friend of mine (he was the head of the physiology department as well as the dean of the medical school), and he said, "Well, what did you get in chemistry?"

And I said, "Ninety-seven."

He said, "What did you get in physiology?"

I said, "I got a D."

He said, "You know why?"

And I said, "Yes."

He said, "Well, I'll give you a pass," but that *pass* kept me from AOA.

The D in physiology was for misbehaving. We were just too young. I was only nineteen years old, and the other kids were only nineteen, twenty, twenty-one, and we were too full of energy and they just didn't keep us busy enough. They would give us three hours of laboratory work, and we would be through in an hour at the most, and then we had to sit there for two hours. You can't sit four energetic kids in a place and keep them tied up for two hours without them getting in trouble. We got into all kinds of trouble. I think the thing that precipitated it was that I went up to the professor's sign-out counter to get something, and somebody yelled Duck! One of the kids had thrown a frog at me, and I ducked, and it hit the professor in the face. He never said a word, but that was what gave us a D...along with all of the rest of the stuff that we did. Everybody laughed their heads off, and I knew we were in hot water.

When we were seniors our class was the first one to be subjected to a comprehensive examination. We were given only two weeks advance notification that it was going to happen. We just had to hit the books and the notebooks. We never could understand it: never knew why they did it. I think it was directed specifically at our class, because we'd been a thorn in their side from the time we got there. We got off on the wrong foot that first year, the whole bunch of us, and when you get started that way I guess it follows you through. But we were good students, and we all became damn good doctors, too.

In the comprehensive exams each two students met with two professors over a

period of two weeks, and they reviewed every subject that we had taken in medical school. This was a stressful two weeks, and they found out afterward that that was not a good way to do it. (They said they could have “conditioned” five of the seniors—required them to repeat some work—but we never knew who they would have conditioned.) The end result was that they finally split that up and gave a two-year comprehensive exam after the sophomore year and then the last two years after the senior year. Four years of study was just too much to know and too much to review in two weeks. But, needless to say, not a one of us had to crack a book for the state board exams! [laughter]

Every senior man at that time grew a mustache. Our whole class was mustached from the beginning of the second half of the senior year. That was a tradition that had carried on from year to year at the University of Colorado Medical School. Also, while we were not called doctors when we entered medical school, the faculty started to call us doctors during the last half of our senior year.

Graduation was probably the most exciting day of my life; to walk up and get my degree from the chancellor of the university was absolutely the highlight of my life! Graduation was held at Boulder, and my whole family were there to observe the ceremony and then to celebrate afterward. We came down to Denver and had a big family dinner, and that was it. I already had been accepted at the Salt Lake County General Hospital for my rotating internship, and the last two weeks of June were a period of relaxation—no work, no school, no nothing [laughter]; just visiting and talking to classmates and their families. For graduation gifts I got at least six fountain pen and pencil sets, and probably used every one of them.

INTERNSHIP

I graduated from medical school at the end of May, 1928, started my internship the first of July, 1928, and finished it the thirtieth of June, 1929. It was a rotating internship, which meant that we had emergency work, we had medicine, we had obstetric and gynecology, we had anaesthesiology, and we had fractures.

At that time, all interns took a rotating internship and then decided what branch of medicine they wanted to follow. Only after the internship in rotating fields could they take residency in their chosen specialty. I think now you can enter your specialty directly after medical school and go right into a residency. You decide whether you want to do family practice or want to be a specialist, and then enter that field right away. I feel strongly that every doctor should have a rotating internship, because no matter what his specialty is, he should know the whole body, and so often now they don't. They forget about the rest of the systems and they think of just their surgery or their eye or their ear or their obstetrics; but they *must* know the whole

body, including the psychological aspects of the body.

For my internship I went to Utah, at least partially because my brother Meyer was there. He was my favorite brother, and I wanted to be near him, and that was the best way I could do it. Even if he had not been there, I never would have considered doing an internship in the East. I knew that I'd stay in the West. I might have tried to get an internship at either Colorado General or Denver General, which I think I could have done, but Salt Lake County Hospital offered an opportunity to get out of Denver and be close to the brother that I thought so much of. It was an excellent internship, and I have never regretted going there. Never.

Our training at the University of Colorado fitted us well for practice in Utah, because the men there practiced pretty much the same. We weren't in the ultra-scientific method of medicine that we are today, and the examination and treatment of patients was pretty standard. We had a good basic understanding of medicine, and it was

fortified in our internship. The doctors at the Salt Lake County General Hospital who trained us were all top men. So there was no transition to make: what we learned in school was what we practiced in Salt Lake City.

My brother was working as a surgeon in Bingham Canyon, Utah, in a hospital operated by the Salt Lake County Physician for the mining companies. The Salt Lake County Physician was also nominal head of the Salt Lake County General Hospital, so my brother had me apply there, and of course it was a shoo-in. There were four interns at the Salt Lake County Hospital—three from Iowa and me from Colorado. There were three rooms in the basement and one room upstairs. Two of the men from Iowa and I roomed down in the basement between the furnace room and the morgue. [laughter] It wasn't very pleasant, but it was a place to sleep.

The internship was a wonderful internship. They had a great staff of doctors. My first three months were on emergency; that meant taking care of the emergency room. All of the automobile accidents in Salt Lake County were brought in there. My first day there they brought a boy in from Bingham Canyon who had held a dynamite cap and hit it with a hammer and blew off most of his fingers. I went in to tell the county physician, who was the chief of staff, that this boy was here and I had cleaned him up and he was ready to be taken to the operating room. The county physician said, "Well, go ahead and take him up, doctor; it's your case." I had not done very much work with finger amputations and repair of stubs, but I thought, "This is the way it is; here we go." So we got an anaesthesiologist, and I repaired the boy's hand. I did give him two fingers that were usable afterward, and stumps that were cleaned, and I was real proud of my first

case. I was not apprehensive about doing that surgery. You know everything when you are young! [laughter]

I had been in my internship for about six weeks when Dr. Stroup—who was the county physician and who owned the Bingham Canyon Hospital, which serviced the five underground mines—asked me if I would like to go up there and work for a month while my brother took his vacation. I was happy to do this, as long as it did not interfere with my internship. It turned out to be quite an experience!

Bingham Canyon attracted violent, criminal men. It was a hard place to work in—mostly underground mines. (Of course, Utah Copper had an open pit.) I think the underground mines brought in a lot of criminals who were really hiding out; it was a good place to hide out, apparently, from what I understood of the area. After I had driven up to the hospital one of the first persons who came to see me was the sheriff, who brought me a .38-caliber revolver and said, "Doctor, you better carry this with you." And I thought, "It's an awful place where you have to carry a gun to practice medicine." I did not carry it; I put it in a desk drawer and locked it up and gave it back to the sheriff after I finished my tour of duty up there. A few nights after I had arrived at Bingham I was called to a residence in the Canyon at about five o'clock in the afternoon. I got out of my car, and about twenty feet in front of me was the body of a man who had been murdered by gunshot. Before the night was over I had signed four death certificates: two from gunshot killings and two for the deputy sheriffs who had a very serious car accident chasing these hoodlums. Bingham Canyon had the dregs of the world in it, and it was probably one of the most criminally infested areas in the country at that time.

At Bingham Canyon, I worked with Dr. Paul Richards, who was one of the outstanding industrial surgeons of the West at that time. The month that I spent under Dr. Richards had a great deal to do with my eventually becoming involved in industrial medicine and surgery. He was a very domineering person, and whenever there was a case (either we went into the mines to get the injured men ourselves, or they were brought in), after the x-rays and the diagnosis had been done, he would say, "Go ahead doctor, I'm busy. Go ahead and fix them." So I got a chance to fix compound fractures and broken backs and sew up all kinds of lacerations as an intern—experience which I would never have gotten in any hospital. The month there was really a very worthwhile month and probably influenced my eventual move to industrial medicine and surgery.

Industrial medicine and surgery involve the treatment of the working man—primarily miners at Bingham Canyon. There it meant all of the traumatic medicine and surgery that were necessary to treat injuries caused by accidents in the mines. And they had *lots* of accidents in the underground mines at that time, plus inhalation of dust and gunpowder smoke, and.... You also practiced general medicine along with the industrial, because you took care of the miners' medical ills, and their families and their children. So it was a wide, general practice with the emphasis on industrial medicine and surgery.

The mines in Bingham Canyon were mining gold and silver, primarily, and some copper. Of course, the big mine there was the Utah Copper open pit, but they had their own hospital and their own medical staff. We were not involved in the care of those people, just the men who worked in the underground mines.

When I returned to my internship from Bingham Canyon, Salt Lake County Hospital had hired a new instructress of nurses by the name of Josephine Elbert. She was there about five months when she was made superintendent of nurses. We got to know each other, and she was the woman whom I eventually would ask to be my bride. We married about four years later.

The month at Bingham Canyon was counted as part of my emergency service internship. It was nothing more than that, but it gave me much more opportunity and much more varied training than the hospital emergency room would give. Life did not get any easier in the second three months. It never got any easier. It was a hassle; every day was full, throughout the internship. In the second three months, I moved on to medicine and anaesthesiology. I learned how to give anaesthetics and took care of just medical cases at that time; and occasionally I would assist in surgery, but not very often.

We had a nurse anaesthetist, and she taught us how to give anaesthetics, such as they were, but we really didn't get good training in anaesthesiology. We could give an ether anaesthetic or a gas anaesthetic, and, of course, we used a lot of local anaesthetics for lacerations. Our anaesthesia was not the best and not too well supervised, but we didn't get into trouble with it, either, perhaps because we were too frightened of anaesthesia to put the patients down too deep.

In the anaesthesia medical part of my internship I took care of a group of cerebral spinal meningitis cases. Out of the 125, we lost none, and only two or three had any permanent damage; so our treatment must have been pretty good. That was probably the worst epidemic we had, but other than that we encountered just run-of-the-mill medical

cases. We had a lot of elderly patients. They had an infirmary for the older people on the grounds, and we took care of them. It was just routine upper respiratory problems, pneumonias, tuberculosis, heart attacks, heart cases, nephritis, kidney problems, ulcers, bleeding ulcers, cancers, appendices, hernias.... It was just good general practice; just family practice.

My third three months were obstetrics and gynecology. I had done a lot of obstetrics, but this was a real experience: I learned how to do Caesarian sections; I learned how to do forceps deliveries; I learned how to do versions and extractions, and I learned how to take care of ruptured tubal pregnancies—to operate on them and all of the complications that go with obstetrics. Along with that, you also were the second anaesthetist, so you were busy giving anaesthetics and occasionally assisted in surgery.

From the obstetrical part of internship, I went on to my final three months, which was surgery, and this was a delight. Every week we did two days of tonsils. I did an average of ten tonsillectomies twice a week, and these patients were just kept in the emergency rooms until they could go home. Then we operated almost every day and some nights, and it was a real training in surgery. We did all types of surgery, from the top of the head to the bottoms of the feet, and I had excellent surgical training. I would do all the night surgery, at first by calling in one of the surgeons on the staff, and the last two months by just going ahead. I would let them know that an acute appendix or a strangulated hernia or a ruptured ulcer were in, and ask if I should go ahead. They would always say, “Go ahead, and we will see them in the morning.”

Surgery appealed to me very much; I don't know why.... But I liked it all: I liked medicine and I liked obstetrics and I liked

the emergency work. It was all good, and I really can't say that I liked one better than the other. I just wanted to be a whole doctor and be able to take care of the whole body.

As interns, we were paid fifty dollars a month, of which we were given thirty dollars at the time. Twenty dollars was held out every month until the end of the year so we would have enough money to get out of town; and I am sure that's exactly why they did it that way! It was very minimal pay for all the work we did. However, I was all right in the internship. I didn't need any help, because I had my room, board and laundry provided, and I had no car; so I had no expenses except clothes, and those were hospital uniforms except for what I brought with me.

By interning in a county hospital, I found out early in my career that poor people hurt just as much as rich people, and I made up my mind that whenever I took a patient they would get the same care, no matter what their color or their creed or their financial situation. I have kept to that my whole life.

McGILL: INDUSTRIAL MEDICINE IN A COMPANY TOWN

After finishing my internship I had no special plans to go anywhere, but I didn't want to practice in Salt Lake City or go back to Denver. I had to find something to do to live, so I took on a job as the house physician at the Newhouse Hotel, which gave me a free room. I would see patients for the hospital whenever they needed a doctor, which was another source of income. Additionally, I had promised several of the doctors in Salt Lake City that I would do relief work for them while they took their vacations, so at one time I was running five offices in Salt Lake City, including a pediatric office, an internist's office, an OB-GYN's office and two urologists' offices. I was the busiest doctor in Salt Lake City—operating, running around making house calls, working in the hospitals. It was just great for a few months, but it was too hard; it was too many hours. And the relief work that I did was all on a charge basis, so I received no cash until the end of the month, when I would get my share of the fees that I had charged for the doctors that I was working for.

My decision to become a general practitioner followed this experience, and it was due more to circumstance than to anything else. For almost five months I had been relieving one of the urologists who had been sick, and I had to make a decision as to whether I wanted to go on with urology or not. These men had trained me well, and I was able to do most of the procedures for a urologic beginner. At the same time the chief surgeon for the Nevada Consolidated Copper Company, situated in the Ely mining district of eastern Nevada, came to the office and told Dr. Goeltz, my superior, that he had an opening for a young surgeon. He asked Dr. Goeltz if he knew anyone who would like the job, and Dr. Goeltz said, "Yes. I've got a man here in the office that I'll introduce you to." So I met Dr. Bowdle, and after about thirty minutes Dr. Bowdle and Dr. Goeltz and I all felt that Nevada Consolidated Copper would be a good place for me to land. The inducements I was offered were \$330 a month, room and board, laundry, all office expenses and all car expenses, all

licenses, all organization memberships and everything paid. It was really a very lucrative job compared to what men in private practice were doing at that time. So, I accepted the job as an assistant surgeon for the copper company in the Ely district.

My experience in Bingham Canyon somewhat influenced me to take such a similar position in the Ely district, but the principal determinant was that I needed a job. It was a matter of survival rather than any particular focus on industrial medicine, because I liked every bit of medicine; it didn't make any big difference to me what I did. Of course, I liked surgery—that was where the excitement was. I think most young interns feel that surgery *really* is where the action is, and it is probably true. The other parts of medicine are just as interesting and just as challenging, and they give us as many rewards with a successful case; nonetheless, taking the industrial medicine position offered by Nevada Consolidated Copper gave me a greater opportunity to do a lot of trauma work, a lot of surgery.

The Nevada Consolidated Copper Company was located in the Ely district—the mine being at Ruth, the mill and smelter in McGill, and the Nevada Northern Railway (which was part of the company) in East Ely.* There were two emergency hospitals—one at the mine at Ruth and one in McGill. The main surgical hospital, the Steptoe Valley Hospital, was in East Ely, midway between Ruth and McGill. Of course, the Steptoe Valley Hospital was where all of the major work was done. The emergency hospitals would take an emergency and then transport the injured or sick person to the Steptoe Valley Hospital by ambulance, of which we owned our own.

When I arrived in White Pine County in 1929, I had passed the state boards in

Colorado and had an active Colorado license; I also had a license in Utah and applied for a license in Nevada, and by reciprocity got the license without having to appear before the Medical Examiners Board. In those days, I am sure that if a good friend was practicing here and you came into Nevada, you would have no trouble getting a license, no matter what your credentials were. [laughter] They were very lax, and it was just a friendly type of thing. Doctors were not the only ones.... At that time the dentists had a closed corporation in Nevada, and if they didn't have a real need in Reno or Ely or Las Vegas for a dentist coming in from out-of-state, he could never get a license. The only way he could get a license, no matter *what* his credentials were, was by some dentist in one of the towns saying, yes, they could use another dentist! That wasn't the way the physicians worked, but the dentists did, and I speak from personal experience about them.

When I took the job, I actually knew nothing about the Steptoe Valley Hospital, except that it was accredited by the American College of Surgeons, which meant that they practiced good medicine there. The man I was working for assured me that it was a well-accredited group of doctors, too. Dr. Bowdle was a qualified surgeon, and all of the men that he had with him were good medical people. Doctor Bowdle's assistant chief surgeon, Walter Frolich, had had many years of training in San Francisco. He was just a pure surgeon, but he was one of the best surgeons that I have ever seen work.

*Nevada Consolidated Copper became a wholly-owned subsidiary of the Kennecott Copper Corporation in 1933. It later went by the name of the parent company.

The rest of us, except for the two surgeons, were general practitioners. Each emergency hospital also had one nurse, and the main hospital had about fourteen nurses. They used nothing but graduate, registered nurses; they didn't use nurse's aides.

My assignment was to be in McGill where the mill and the smelter were, but on relief work I would relieve at the Steptoe Valley Hospital or up at Ruth, depending upon where they needed someone. McGill and the Steptoe Valley Hospital were about two hundred and fifty miles from Salt Lake City, which was the next nearest center, so medically and surgically practically everything was done right there. The only cases that were sent to Salt Lake City were eye surgery and brain surgery.

I arrived in McGill the afternoon of the fifteenth of November, 1929, and met the man who was to be my senior—Dr. Hovenden, who was a typical western-style doctor, rough and brusque. McGill at that time was the second largest city in the state of Nevada. Reno had about twelve or thirteen thousand people, and McGill had about seven thousand. It was a very nicely kept town: the streets, sidewalks and curbs were immaculately clean, and people seemed very happy there. The company was like a family to them. The company owned its own power plant, and the electric power was sold to citizens at minimal rates. They had their own dairy and, as I recall it now, milk and cream were about five cents a bottle, and the cream was the kind that you had to spoon out of the bottle; it didn't pour.

The only private establishments in McGill at that time were a dry goods and grocery store, a little restaurant, a drug store, a garage and a little clothing store. The rest of it was all company-owned. The company ran a big commissary where the people bought most of

their food, and at that store the food was sold to them at 10 percent over cost. Of course, they didn't accept hard currency in the store—they used coupons. The wives or the husbands would buy coupons from the cashier, and they would use that in the company commissary.

All of the houses were owned by the company, and the rent was three dollars per room per month. The company would give all their employees paint, and they would have to paint their houses. Soil was hauled in for yards, and the residents would have to take care of them. But the higher officials had all of this done for them. Their houses were painted; all repairs were done; all the gardening was done for the executives. Typical army stratification of the people. Yet, it was good.

There was a union, but the union usually was very passive, which was all right for them because our men didn't strike. Our men worked all through those periods in the 1930s when mine and mill workers struck in Utah, New Mexico and Arizona, and then they were given the same raises retroactive that the other fellows that had struck in the other states got. So by being passive they really gained financially and in every other way, because they kept working all through strikes.

There were a few little ranches around McGill, and a few other little mines in the area; but the backbone of the whole Ely district was the copper company. In Ruth and McGill and East Ely the company had complete control over schools and libraries and everything else, but we had *good* libraries and we had a *good* school system. The company treated the schools very well; they thought the children should get a good education, and they saw to it that they did. They also furnished a nurse at each school in the copper towns to see to the children's needs. In fact, every child was given a complete physical at the beginning of

every school year, and we immunized *all* of the school children every year at no cost to their families. A sick child was seen almost immediately at school, and there was no hassle about who was going to see them.

There was a school board, but in the company towns the trustees were all people who worked for the company. The trustees were not elected—they were appointed by the general manager—but they were always really good people from the management class. Consolidated Copper Company at Kimberly ran a very similar operation. Now, Ely was a private town. It had its own county hospital, the White Pine County Hospital. They had their own private physicians who were not involved with the company, and Ely was not a company town in any respect.

McGill was quite a segregated town. The Circle, which was the center of activity, was where the officials lived—the general manager, the assistant general manager and some of the superintendents. Next was Middle Town, in which lived all of the mechanics and engineers. Then there was Upper Town where less-trained people lived. Lower Town was where the laborers lived, and it was divided into ethnic neighborhoods: Greek Town was where all the Greeks lived; Austrian Town was for the Austrians; and there was Jap Town, where the Japanese people lived. Steptoe was an area above the pipeline which did not have any running water, and where common laborers and off-and-on help lived. Then there was Ragtown, which had been an old house of prostitution, and people were living there.

The Junction was the junction of the railroad that led off to meet the main line of the Southern Pacific and Western Pacific. The surrounding area north of us was Cherry Creek, which had been a huge mining

community at one time with a population of thousands, and which now had 150 people. South of McGill were Ely and East Ely. A little bit west of East Ely were Lane City and Riepetown; then a little bit further on was Ruth, where our open-pit copper mine was, and Kimberly, where the Consolidated Copper Corporation had a mine. Then southwest to Lund and Preston, and then on to Baker. And this was the configuration of the area in which we practiced medicine at that time. It was a big area, and we had probably about fifteen thousand people living in the whole area.

McGill was, of course, entirely a company town, and employees could only rent through the company housing office, so the pattern of segregation by nationality *may* have been partially imposed by the company; but it was assumed that this was the way it should be. There was no formal declaration; this was just the way it was. The arrangement by ethnic neighborhoods was in effect long before I got there, and it never changed in the twelve years that I was there. Everybody was happy with it that way.

There were definitely material differences among the neighborhoods. The Circle got everything that a home needed without any question. Their yards were taken care of, sidewalks were cleaned of snow in the winter, lawns were cut and manicured. In Middle Town (with some exceptions) and the rest of the town, if you needed to paint your house you had to get an OK, and they furnished the paint but you furnished the labor. The privileged hierarchy included the doctors and the superintendents and the foremen, all of whom were taken care of—our homes were painted, and any needed repairs were done free. Our heat and electricity cost us nothing, and we had someone to tend the yard. The remaining neighborhoods—Austrian Town,

Greek Town, Ragtown, Steptoe, and so on—were furnished with house paint and all of them were given major repairs; but anything that was not a major repair was taken care of by the renter.

Social events were segregated. If the general manager's family had a party, only certain higher-ups were invited; but the doctors usually got invited to everything. We went to all of the christenings and all of the church things for the families. Of course, the Austrians and the Greeks were great celebrators of birthdays and holidays, and we were always invited to those celebrations. But the upper echelon very seldom went to those things. It was segregated just about the way the army is—the commissioned officers, non-commissioned officers, and then the privates. They are all separated in the army and so were the people in McGill.

There were occasionally dances to which everybody was invited. There was a club called the Stray Antlers, which was a branch of the Elks. It had a nice dance floor, and there were a lot of parties and dinners there to which everybody was invited.

The only civic government in McGill was in the person of the general manager. He called all the turns. The school board was hand-picked by the general manager, but we had good schools and good teachers. It was really remarkable. The company saw to it that the school buildings were well taken care of, and that the teachers had a good dormitory and kitchen.

There was a group of men called the bull gang, who were called on to just do day-labor types of things. They dug ditches and laid rails and helped with repairs. They were people who had no training, and they would be from all ethnic groups. In fact, some of our own American children would be in the

bull gang in the summertime because they had no training for specialized work. In other job classifications there did appear to be some division by ethnic group, but this was an innocent thing and seemed to come about mostly from the hiring practices of the foremen rather than from any company effort.

The Greeks worked mostly at the mill dumping the ore cars and working in the crusher. There was a man of Greek descent who was foreman, so, naturally, he hired Greek men to work in the crusher. In the late 1930s the company put in a mechanical car dumper and a big jaw crusher. The car-dumper would dump the ore from the loaded cars into the jaw crusher, and a thousand men, mostly Greeks, were laid off from their jobs because of it. Many stayed on in McGill and were finally given other work.

A lot of the Austrians were good mechanics. Of course, the Greeks were good, too, but there were so many more of them. The Japanese were primarily kitchen help and track laborers and janitors. Blacks rarely showed up to apply for jobs, and we had only two black families in all the years that I was in McGill. They were fine people and good patients. I think the men worked at jobs in the smelter. There were a few blacks working at the mine at Ruth and there were some on the railroad, but not very many. I think there were not over half a dozen black families in the entire Ely district when I was there. The two black families in McGill lived in Lower Town, across Highway 50 from the business area.

Greek Town was located in Lower Town. When the company put bathtubs in their houses, some of the Greeks really didn't have much use for a bathtub, so they used them to store coal in the winter. [laughter] But they were used to very primitive and simple living. Of course, all of the houses were owned by the

company and they built them pretty much alike. The houses in Middle Town were a little better constructed than the ones in Upper Town or Lower Town, but all were adequate. With all the houses, there was plenty of space for vegetable gardens, and they all had gardens—even we had a garden. There was also plenty of yard space for the children. The houses were not crowded at all.

Company houses rented at that time for three dollars a month per room, so that a four-room house would rent for twelve dollars a month when I first went there. Eventually that was raised to five dollars a month per room. During the Depression our production of copper was lowered, and we were only working part-time. Then the men were charged for rent, electricity and dairy products only for the days they worked. On the days that the company didn't need them, they paid no rent, electricity or milk bill. I thought that was an unusual way to help them weather the Depression, and really a very fatherly way of doing it. But even during the Depression, Kennecott made money selling copper for five cents a pound. The reason was that they got enough gold, silver and platinum out of the ore to pay for all of their operating costs. We were known as a copper mine, but we did extract a lot of rare metals also, so that it made the cost of our copper very low and we could compete in world markets.

The emergency hospital was in Middle Town. I had an apartment in the hospital before I was married, and my meals were all furnished at the boarding house [dining hall] and my laundry was done for me. The single laborers roomed in dormitories, and the single engineers lived in a building called the Club House, on the ground floor of which was the McGill Library, started and kept up

nicely by the company. Whenever the Club House was full, single engineers lived down in the dormitories too, unless they could find a room with a family. A lot of educated men lived in the dormitories, and it didn't bother them.

Of course, we single men all ate in the boarding house. The boarding house space was partitioned into a staff boarding house and everybody else's, so that we had a room of our own which seated probably one hundred and fifty staff and engineers, et cetera. And then the other one seated about six hundred laborers. The meals served in these dining halls were American, and that was one place the company didn't spare anything. They had a good chef and a good foreman over the kitchens, and the food was good. I never hesitated to take a guest down there for a meal. The cooks were Greeks, and there was a Greek baker, but no Greek items ever showed up on the menu. It was just straight American cooking.

Medical care was very cheap for the workers because the men were totally taken care of by the company. All medical care, all medicines, all hospitalizations, surgery or repair of any hernias or fractures cost the company men not a thing, even when they weren't working, as long as they were on the payroll and listed as a company employee. The families were given free ordinary medical care. They were charged only for obstetrical deliveries, surgery, fractures, and x-rays and laboratory work. Even house calls were free, and office visits cost them nothing. They did have to buy their own medicines, and for that, the men paid a dollar a month for the entire family, which was really quite a reasonable thing.

The health of the community was pretty stable, level and consistent across all ethnic

lines. And as far as I was concerned, every patient that came in—from the general manager to the lowest man on the rung—was the same. But I can't say that my associate took the same approach. Dr. Hovenden was a real brusque, rough guy, and he would sometimes give an ethnic patient a bad time... not physically, but verbally abusing them. Austrians, Greeks, Japanese...all of them. I heard it many times and I thought it was certainly unfair. He would ride roughshod over them sometimes, depending upon his mood. The quality of medical care that Dr. Hovenden provided them was good, but he just didn't like the way they acted; so he would chew them out for reasons I never could figure out most of the time.

When I arrived at McGill I was given a small apartment in the emergency hospital. I had two rooms and a bathroom—a bedroom and a living room, nicely done and nicely furnished; it was very comfortable, steam-heated, and everything a single man would need. I ate all of my meals at the boarding house cafeteria. This was in the emergency hospital at McGill; in the Steptoe Valley Hospital, the only staff who lived there were the nurses in the nurses' quarters, a separate building. Doctors all lived in homes around the hospital.

At the McGill emergency hospital there was one other doctor; there were two of us at McGill, two at Ruth, and four men at the Steptoe Valley Hospital. Whenever help was needed at Steptoe Valley for surgery or anaesthetics or anything else, one of the men from Ruth or McGill would go and help out.

We did not exactly share the shifts equally at the McGill emergency hospital. [laughter] It worked out this way: the young man usually took twenty-four hours, six days a week. And I was the young man. [laughter] You

got one night off a week, and you got every other Sunday off. We worked! But it really wasn't that bad. You could get a night off whenever you wanted, but I worked most of the time. Initially, we were on call twenty-four hours a day because the plant was working twenty-four hours a day. Then, during the Depression, when it started to slow down, of course, we slowed down.

We always had office hours from nine o'clock to noon, and two to five o'clock, and seven to eight o'clock, five days a week. On Sundays we kept hours from nine o'clock to about noon. The reason we had the night office hour was because we had a plant that was working twenty-four hours a day, and it gave the people who needed medical care a chance to get in. We saw a *lot* of people. We also made a lot of house calls and saw most of our sick children and sick women in their homes. I would make up to twenty-five house calls a day, making them before nine o'clock in the morning or between noon and two o'clock in the afternoon, or after five o'clock.

I would usually get up about six o'clock in the morning and go down to the cafeteria and have my breakfast. Then I would be out in my car making calls before eight o'clock. When I was very busy I would be out making house calls by seven o'clock in the morning. They used to say I would wake them up. I would work house calls until nine o'clock, come into the office and work until noon. Of course, we were never through at noon—it was always after that. I would go down and get my lunch at the boarding house; then I would go out and finish what house calls I had and what new ones I had picked up in the morning, and be at the office about two o'clock in the afternoon. I would finish about five o'clock, go down and have my dinner and make any other house calls that I had between dinner time and seven o'clock in the evening, and be

back at the office at seven o'clock and work until eight o'clock or whenever we finished. And then if there were any calls, we would go out and make them. That's a full day.

It wasn't that busy all the time, but many, many days were completely filled with work. We had seven thousand people in McGill, and here were two men trying to take care of all of them...or most of the time, one man. [laughter] The older doctor didn't like too much of the night work. When I got there, I was asked to do the OB deliveries, so lots of times I would be out at night delivering babies. We delivered them in their homes, of course, and sometimes I would stay there all night with them, lying on a couch or on the floor—whatever was convenient.

The only staff we had was a graduate nurse who worked from nine o'clock to noon and from two to five o'clock. She did not work at night. She would answer the phone; she would keep a list of calls for us and tell us what was going on. She would also go out and give the anaesthetics and take care of the OBs with us.

There was no screening procedure to determine whether or not somebody actually needed a doctor. Very few houses had phones, so at night if someone wanted the doctor, he had to come to your quarters and get you, because there was no way to call you. Usually, if a man got up—especially in the wintertime—and came to get you, you knew that you better go out. If they did not have a pressing need, they would wait until morning.

I had already had a taste of industrial medicine in Bingham Canyon, but when I came to McGill I encountered a different situation. The equipment at McGill, Ruth and East Ely was the best the company could buy. We had anything we needed in equipment, and also excellent supplies and excellent

help. They were very generous with us. It was superior to anything you would get in a county hospital, and superior to what you would find in most other hospitals. We had the best of everything.

Our staff met at least twice a month, and we all would review the new things that were out, and discuss the new procedures, the new medications, et cetera, so that we kept up really well. At the Steptoe Valley Hospital we were accredited by the American College of Surgeons, who came out and inspected us and gave us accreditation every year, which is something a lot of hospitals didn't get. This was the way it had to be, and all of us took post-graduate work every year so that we kept up. We would go to Salt Lake City or to San Francisco or Denver for a week of training. This was a necessity, because we were isolated from specialists. If you got some patient with a rare condition you had to figure it out for yourself. You didn't have anybody to talk to; you were your own consultants.

Medical practice in McGill was really an interesting situation. We would get fractured arms and fractured legs and we would reduce them there at our emergency hospital and put on a cast or a splint. I recall one person, Bill Ireland—a child of three who eventually became the athletic director at the University of Nevada-Las Vegas—who fell off of his father's garage and broke his femur. I fixed him and put a cast on at home and then took him over to the hospital in East Ely for x-rays, and found that I had done a pretty good job. That was the way we left him. Six weeks later we took the cast off and he was up running around on a perfectly good leg. He turned out to be quite an athlete.

We fixed fractures, and then we would take them over to the hospital for x-rays, because we did not have a machine in McGill. Occasionally we would have to remove the

cast and do a further reduction because we hadn't gotten it quite correct, but most of the time our reductions held up real well. They were accepted by people like Don King, professor of surgery at the University of California in San Francisco, who used to come to McGill and look at our work sometimes. He would hold a crippled children's clinic, he would look over a lot of our stuff and look our x-rays over, and he was pleased with the type of work we did.

We had lots of bad lacerations, but we had no anaesthesia at McGill except locals. Anything that needed a general anaesthetic would be taken over to the Steptoe Valley Hospital, but we would sew up very bad lacerations under local; clean them up. We also would do some minor surgery, such as removal of small tumors of the skin, or fatty tumors, and we would do biopsies for pathologic reports. We took care of our pneumonias at home—we didn't x-ray them, but we clinically knew what they had. Oxygen and intravenous feedings would be given in the patients' homes, and we gave transfusions in their homes.

Obstetrics was a busy practice in McGill. We had a lot of Latter Day Saints [Mormons] people, and they had big families. Of course, we did our deliveries at home. We carried all of our own instruments in sterile wraps from the office so that we had everything that we needed in the home, but if the case was too complicated, we would transfer them by ambulance to the Steptoe Valley Hospital, which would only take half an hour. But there were very few that we had to transfer from McGill to the hospital. Over the years I think I delivered about thirty-five hundred babies in their homes in McGill.

Based on experience, I think that a pregnant woman does better if she is in her

own environment with her own family than she does in a hospital. There are times when it's urgent that they be in a hospital, but many, many women could deliver at home and be much happier. Our home-birth complications were very minimal—not any more than any hospital—and our infant mortality was lower than in most hospitals, because we knew when a patient should be put in a hospital. We knew when one would need a Caesarean section, and usually this was the main reason for going to the hospital. However, we used to put on forceps in the homes and we gave intravenouses, and we even gave transfusions in the homes for patients who bled too much. You couldn't do that today.

McGill eventually ended up with a six-bed maternity hospital run by a Mrs. Heber Behrman, who was an excellent nurse. Mrs. Behrman's mother had been a midwife over in Lund and Preston, which were the Mormon communities south of Ely, and then moved to Ely and ran a little maternity hospital. Mrs. Behrman decided that she would try to do the same in McGill, and asked if it would be all right with us. Both Dr. Hovenden and I agreed that it would be an excellent idea, so she eventually fixed up her house so we could take care of six obstetrical cases there. It was a wonderful place to have them, because she would watch them in labor and we wouldn't have to stay with them all night like we used to do in the homes.

Any of the mothers who could afford the five dollars a day would use Mrs. Behrman's maternity hospital. It didn't depend upon the difficulty of birth; it just depended upon whether they could afford it. It was just nicer to give birth in the maternity hospital than it was at home, and the little maternity hospital was usually filled. I delivered hundreds and hundreds of babies in Mrs. Behrman's hospital.

Mrs. Behrman was just great, although she had no formal training in midwifery. (Her mother, who *had*, was a midwife who delivered many, many children out in the boondocks, and many difficult ones.) But Mrs. Behrman knew when a patient was ready to deliver and knew if there was trouble, and she would call you right away. Although it was not her practice, she *could* deliver a normal baby, and she knew how to take care of the afterbirth and everything else. She was very capable, although she rarely had to make a delivery. You won't find this sort of arrangement today, but we felt it was the way to go because it was great for us and it was great for the patient. You can't deny a thing that works, especially one that worked so well. But times have changed. I don't think now....

At McGill in the 1930s many of the laborers and their families were from the Balkan countries and Greece and Italy and Japan. They brought with them some of their old home remedies, such as the onion poultice for pneumonia.... Each ethnic group would ask if we minded if they used certain poultices, teas and other concoctions. Of course, you had to let them use them. They were used to them, and this was just a part of medicine in McGill. We let them use their own treatments along with medicines we thought they should have, and prescribed for them.

Some of the home remedies were particularly effective. Mustard poultices for pleurisy and pneumonia really did some good as counter-irritants. We eventually used Vicks and things like that which are similar. Of course, there was the old superstition that if you hung a piece of asafetida around your neck, you wouldn't get the flu; and they would come in with that on, and, of course, we would leave! [laughter] A lot of the old teas

and herbs that were used as ancient remedies are still being used in medicine, although in the purified form. You can't argue with a successful thing. And this is true: We weren't the only ones that had all the knowledge!

There were some industry-related health problems that were more common in McGill, particularly in the first few years I was there, than they would be in the population at large. Obviously, we were getting a lot more broken bones; and we were dealing with a lot of hot metal and we used to get a lot of sparks in eyes and have to dig the escar out. We got pretty good at that. Occasionally we would get an eye with a piece of metal in it, and we would send that patient right to Salt Lake City because we could not handle it. The men were issued protective goggles, but you know how workers are—lots of times the goggles were up on the forehead, not over their eyes. Then we had a lot of bad burns from the molten metal—burns bad enough to need amputation of an extremity; and we had lots of crushing injuries, especially where the ore was dumped. Where the mill and smelter were, they had what was called a tailings pond. It was square miles of dry, dusty exudates from the mill. Dust would blow in the wind, and lots of times you would have to stop your car because you couldn't see where you were going. Interestingly, I never found that the dust caused any pulmonary problems in McGill. With the thousands of chest x-rays that I took, I did not see any problems from the dust...but it caused the women a heartache almost every day. The wind blew a lot, and the houses would just be covered with dust inside. This area was a man's country; it wasn't a woman's country, but the women put up with it as best they could.

Among the families, the women and the children, we encountered only those health

problems that you would encounter in any average American city—measles, chicken pox, whooping cough, pneumonia, head colds, tonsillitis, abscessed ears, pneumonia, appendicitis, ruptures, broken bones, lacerations...everything that you find in a general practice anywhere. But the thing that the company was most concerned about was the health of the men, because they were responsible for their health and for their accidents. Of course, we had ties with the Nevada Industrial Commission, but they just came and rated the permanent disabilities. We took care of all of the rest.

In the early 1930s we had a tremendous number of industrial accidents, and we physicians asked the U.S. Department of Mines to send somebody from the mining group to start first aid classes. (We called them First Aid and Safety First.) Within a year our accident rate had dropped at least 20 percent, and in the next five years we insisted that every man who worked for the company take the course in Safety First and First Aid twice a year. This was administered by a man from the U.S. Department of Mines, and we would be there with them. In the years from 1930 to 1940 our accident rate dropped by about 80 percent. The daily loss of time dropped with those figures, too, which was a wonderful thing. We had departments that went for years without a time-loss accident, and they were given recognition and financial rewards for this. When the policy went into effect, it affected not only the mill and smelter but also the mine and the railroads.

We really did a yeoman's job getting that accident rate down, because we used to have a *terrific* number of accidents. The workers were taught to wear goggles when around anything that sparked or flew off, to wear gloves, to wear hard hats, to wear hard-toed shoes.... They had not been doing those

things. Then they were taught how to take care of each other. They learned to take care of a burn or take care of a man with an injury, and the end result was that accidents were not only fewer in number but less severe in their effect. We really saved the company a lot of money and also the Nevada Industrial Commission, which paid all of the insurance. Everybody was grateful.

Nevada Consolidated Copper carried industrial insurance through the state, which was a good way to carry it. The only thing the state took care of at our organization was disabilities: they paid for time loss due to injury and for permanent disabilities. But all the rest of the medical care was taken care of by the company. All medical needs were paid for by the company, which lowered their insurance rate by a tremendous amount of money.

The medical load stayed the same or even was heavier during the Depression than it was before. The men weren't laid off; they would work only ten or twelve days a month, but they stayed around. Of course, that led to a little more drinking, a few more fights and things like that. What we saved in industrial accidents we picked up in barroom accidents. [laughter]

McGill and Ely were not as rough as Bingham Canyon had been, but we had our problems with people with guns...particularly in the little town of Riepetown that was situated between Ruth and Ely. Of course, there was a big red-light district in Ely, and other little surrounding towns had smaller versions—they all had their houses of prostitution. And where you had so many single men you had a lot of fights and disagreements—shootings, clubbings, knifings. It wasn't as bad in the Ely district as it had been in Bingham Canyon; still, Riepetown was a hard, hot town. It

was something! The frequency and number of fights at Riepetown were higher than anywhere else in the district, and that was some district in its day!

We had a huge contingent of single men—over three thousand of them in McGill, and many more in Ruth. With unmarried men comprising such a large part of the population, we had a lot of venereal disease—mostly gonorrhea, some syphilis. There were several houses of prostitution in Ely, and there must have been about three hundred prostitutes up in an area called the Big Four, which was a street with the cribs on it. The girls were checked every week, but that is a futile way of controlling a population like that. You can check them one day, and the next day they are infected and give the disease to the men that are serviced by them. Fortunately, the county physician was responsible for checking the girls; the company had nothing to do with it.

It's interesting how moral instruction figures in the practice of family medicine. In the Ely district many families would send their premarital children to us for advice on family planning, sexual mores and things like that, and it gave us a real sense of responsibility for doing something worthwhile. It was a great honor to be able to give these children what I hoped was a bit of good advice on taking care of their spouses and their children as they came along. Many times I talked to the children about waiting to have sexual encounters until they were married. Celibacy until marriage was, in my opinion, a very good thing. Of course, many of those children knew nothing about sexual intercourse, and we would give them advice as to how to approach that when they were married.

Family doctors were considered part of the family in the old days, and families came to

us with *many* problems that were not related to medicine. This is not done very much anymore, and I did not do it that much here in the Reno area, but in the mining camps, it was a very common procedure. Perhaps the families sent us their children for counseling because Ely was a wide-open town with an area of prostitutes that included about two hundred and fifty young women.

It was always our advice to the young men that they not go up and visit prostitutes—that the red-light district wasn't the best place, and that they should wait until they were married before they started their sexual activity. However, I know that lots of them *did* go up there, and probably it was better than the way things are done today with all of the teenage pregnancies and venereal diseases that are rampant. Those women were examined and checked every week; we tried to keep them free from any disease, and we did a pretty good job of it. I used to examine a lot of them, checking each woman for gonorrhea and for syphilis once a week. It was a lot of work, but it saved the customers a lot of problems. Each examination wouldn't take over five minutes, and they would be spread out through the week, so that it wasn't too bad. They came into the office for the checkup, and records were kept for the county and the state. The women were all documented, and any woman who turned up positive was immediately treated and taken off the line.

The tests were sent into the state lab in Reno. The individual women paid for these checkups, but it was a nominal charge, because the state made no charge for running the lab tests. They did that for everybody, not just for prostitutes. All smears and blood tests sent to the state lab were done at no cost to the patient.

We regularly checked the women for gonorrhea and syphilis, but, of course, the

only time we would get a male was if he contracted one of these venereal diseases, and then he would come in to be treated, and we would try to trace the source and take care of that, so that there wasn't an epidemic. And we did *not* have any epidemics, even though the men were not required to use (and customarily did not use) condoms when they had sex with a prostitute.

We never encountered any socially communicable diseases other than gonorrhea and syphilis that would be worth noting. This was before AIDS and herpes and chlamydiae and other sexually-transmitted diseases became rampant. Two problems that we *did* encounter, that were partially due to living conditions, are not seen much anymore in this part of the country. We used to get crab lice, and sometimes head lice in children, and, of course, pinworms were a rather common complaint.

Although condoms were not used, there were few unwanted pregnancies. I think the women approached birth control in a different way than we do today, probably using a sterilizing douche to get rid of the spermatozoa. They weren't required to use either diaphragms or condoms, so they did not, but I don't recall many pregnancies among the prostitutes in the twenty-three years I was there. There might have been one or two. If there were any pregnancies, they probably were sent out of the area for an abortion, and that may be why we didn't deliver many babies among the prostitutes.

To my knowledge no abortions were being done in the Ely area, but they were available in Salt Lake City. In fact, that's where some of the doctors would send women with unwanted pregnancies. There was a man there in Salt Lake City who did a thriving business on abortions, and a good one, apparently—not a back-room or an alley operation, but under

aseptic conditions and he got good results. Our position at the Steptoe Valley Hospital and the two emergency hospitals was that abortions were against the law, so we never did any. In twenty-three years there I saw only one therapeutic abortion done, and it was done to save the life of a woman who was having a severe hemorrhage.

Of course, the special relationship that I had with my family patients, which included some moral counseling, didn't extend to the prostitutes. [laughter] They were making a living there. However, several of them married local men and became members of the community and good family people. Lots of them married right there in the Ely district.

In the 1930s and 1940s, and even recently, hypochondria was more common in females than in males, although we would have it in males, too, and still do. But I think rather than hypochondria it was probably a form of depression, although we didn't recognize it as such until the development of all the new work on mental illnesses. So we probably were remiss in what we did and what we thought of these people. At any rate, we felt sure that they didn't have a physical illness that needed treatment, so we would resort to placebos. The placebos were just milk of sugar tablets, which we gave them free of charge. We knew that they couldn't hurt them any, and if they did them good psychologically it was great. Occasionally we would write a prescription and the pharmacist would fill it. It was always written so that the pharmacist knew it to be a placebo.

In the 1930s we were starting to use phenobarbital to treat psychological disorders, even though, as we now know, it is a depressant. Perhaps it was used because it relieved anxiety. As the research came along, we got other drugs to take the place

of phenobarbitol, but it was a slow, hard process. Of course, the main thing was to be *absolutely* sure that your patient wasn't physically ill, because the greatest mistake is to think somebody is healthy when they really need your help.

In the Ely district, we also had all of the problems of malingering that are to be found in any industrial area. We used to note that a patient would come in to our office on crutches or be carried in with a backache, and the next night be seen dancing in the bar. But it was a small enough area so we could pick up the malingerers; they weren't hard to identify. They would feign an injury, and from NIC insurance they earned almost as much when they were off as they made when they were on...and they had a lot more fun! [laughter] We would handle cases like that by giving them a release to go to work. Once we gave them a release, a copy of that went in to their bosses the next day, and if they didn't show up for work they were fired.

However, in Ely we had a more difficult problem with people who wanted to go to work when they weren't ready than we had with people who wanted to lay off. They needed the money. Workmen's compensation didn't pay as much as a day's wages, so they wanted to get back on the job, and would ask me to release them. Many times I would, and I would ask the boss to give them a lighter job until they got a little stronger. I think I encountered more of that attitude than I did malingering.

The only drug that we had any problem with in the Ely district was alcohol, but it was a real problem! It was just as much a problem then as drugs are now. We used to counsel our patients all the time concerning the use of alcohol. In those days, we didn't have a group like Alcoholics Anonymous,

which I think does a *terrific* job...even better than psychological counseling. Recovered alcoholics talking to other alcoholics is the best medicine that I know of. Then the family has to realize that this is a habit, and they have to help them try to break the habit. It becomes a family affair...and friends, too.

I was probably closer to alcoholism in the Ely district than when I moved to Reno. These were patients; these were friends who were alcoholics! In the Ely district, I would say about 2 percent of the adult males among my patients were alcoholics. A small percentage, but a real hassle. Each one who was married was a problem for his family, so in total it probably involved at least 5 percent of the population, and some nasty situations arose from that.

Some family abuse that we took care of was due to alcoholism. I can recall one smelter worker running his family out with a butcher knife and then stabbing himself, and me walking in to talk him out of the knife and dress his wounds and taking him up and sewing him up. Others would beat their children or their wives, or would get in fights in the clubs, would get beat up, and have automobile accidents like they do today. It hasn't changed; it's probably gotten worse, because we see more of it here in Reno, but it was going on in the 1930s and 1940s over there. We weren't free of that type of thing; we had just normal people, and this is what you get when you have a mix of people.

My experience was that very, very few people who came to the Ely area were drug addicts. In my whole tenure there I knew only three people who smoked marijuana, and they were Mexicans who moved there. However, we did have the same thing that they had every place else—drug addicts not from the district who would come in and try to get prescriptions for narcotic drugs. These occasional drifters

who were drug addicts would be shipped on to the next town. They wouldn't let them stay there. [laughter] The sheriff would take them fifteen miles down the road and tell them to hitchhike on out, and they would. I hate to say it, but I know it happened. When people would come in and we found they were drug addicts (we called them hop-heads) we would call the sheriff and turn them over to him. I felt partly responsible, because I would pick them up at the hospital and point them out to the sheriff and tell him that this was a drug addict, and he would go through this procedure, which I felt very ashamed of.

Addicts who were drifting through would come to the hospital because of their addiction...they were starting to get the shakes and stuff. They needed something, and we would give them an initial injection to relieve their immediate withdrawal symptoms—which we were allowed to do at that time—but no prescriptions. At that time the most common drug addiction was probably morphine, or possibly heroin; however, we had no heroin.

Cocaine we didn't handle, because we used so little of it in the hospital, but we did use a lot of morphine for pain. We used a little bit of cocaine in the hospital, but just as a local anaesthetic in our ear, nose and throat department. We really had almost no cocaine. It was always just a little bottle of a one-percent solution that we got from the drugstore, and it was not any good for a dope addict.

They did *not* want cocaine...they did *not* want codeine because that wasn't strong enough for them. Morphine was the principal drug of choice, and we would give them an injection of that, and later on, after we got Demerol, we would use it; but we gave them only one shot, and then we would send them on their way.

They'd tell you what they were addicted to. A favorite prescription they'd want was one they couldn't spell. It was "di-something," and you would say, "dilaudid." You knew what they meant. And they'd say, "Oh, yes, that's the drug the doctor used to give me." [laughter] That's a real high-powered one. They never got any dilaudid from us, but they did get a shot of morphine, and then they were sent on their way.

We had no real addiction among physicians. The only thing we ran into was one doctor who couldn't stay away from his alcohol, and we had to let him go. He just couldn't stay away from the bottle. But we were always worried about patients who had serious injuries becoming addicted to the drugs that we would give them for the relief of their pain. So instead of using one drug all the time, we would alternate our drugs. We would give morphine for a little while; then we would give dilaudid a little while; then we would give Demerol, so that they wouldn't get used to one drug and end up as a drug addict. That was an acknowledged way of becoming addicted and a very unfortunate way. A lot of patients who had multiple fractures needed a lot of drugs to relieve their pain, and we never refused them a drug when they were badly injured. Later on we would start tapering them off by giving them smaller and less frequent doses until we could stop the drug and give them something orally to take for their pain. That was a common thing, because we saw a lot of bad accidents, and we used a lot of drugs. But I don't think that we ever sent one out of the hospital with a habit.

Shortly after I moved to McGill I was called to deliver a Mrs. Linnel, whose husband Andy was of Swedish descent. As we delivered the baby and Mr. Linnel could hear the baby cry, he put his head in the door of the bedroom and said, "What is it, Doc?"

“Well, it’s a boy,” I said, “but there is another one.”

And he threw his hands up over his head and said, “Oh, my God! If I’d had the other doctor there’d have been only one!”

I delivered a little red-headed patient of her first baby in Lower Town. It was a long, drawn-out affair and I was kind of tired, so I laid down on the couch and there was a pillow there and it was apparently a very fancy and ornate pillow. I put my head on it, and she came out as she was walking around during labor and saw my head on that pillow and she said, “Get your head off that pillow, you SOB! That’s my best pillow.” I *immediately* got my head off of her pillow and sat up laughingly. Of all the things that were going on with this hard labor, that pillow was uppermost in her mind.

Another interesting obstetrical case was with the business manager’s wife. We had decided that she would go to the hospital to have her baby, and she had asked me in the in the course of the pregnancy how long you were usually in labor with a first baby. I said, “Well, it could be up to twenty-four hours and be perfectly normal.” One noon after lunch the husband stopped by the office and said, “Doc, I wish you would look in on Helen. She’s had a lot of abdominal pain and she’s lost some water on the carpet.”

As he left I told the nurse, “We had better get down there. Sounds like she is going to have a baby,” which she did on the living room couch. We never got her off of it, and it ruined the couch. We got a nice baby boy for them, but she gave me a bad time. She said, “You told me it would be up to twenty-four hours, and I’ve only been in labor six hours.” But her sister, who had had a set of twins, didn’t realize that she hadn’t just passed urine, her membranes had ruptured—that was the gush of water that she’d had. But it all turned

out fine. They named him Junior and I was forgiven. [laughter]

I was occasionally asked to perform as a veterinarian. The children would bring their dogs and cats in, and we would take care of them. I x-rayed lots of dogs at the Steptoe Valley Hospital for broken limbs, and put splints on them. I doubt that would go on today. Sure, we saw animals—they were just part of the family—but other than a bull with an eye infection, we didn’t do any large animal veterinarian work; that was too tough! [laughter]

A bull at the dairy in McGill had developed an infected eye. There was no veterinarian practicing in the area, so I called Dr. Palmer, an eye specialist in Salt Lake City, and asked him what to do with it. He said, “Well, open it up.” What he forgot to tell me was to put some local anaesthetic in the bull’s eye before I did this! So the men put the bull in the dehorning press, and I walked up to the bull and pulled the eyelids apart and cut the eye open...and with that, this bull exploded, tore the dehorning press apart and started after us! We *all* had to get over a six-foot fence to get out of his way. What an experience!

I came home and Jo said, “What have you been doing?”

I said, “Operating on a bull.”

And she said, “I can’t believe it!”

And I said, “Well, you can now.” [laughter]

The incidence of pneumonia at that time was probably higher than it is now, because we did not have the anti-pneumococcus serums that now protect a lot of the older people, particularly. We took care of our pneumonia patients at home using a nasal catheter and oxygen and giving them intravenous feedings, and when the antibiotics started to come out, the treatment was minimized and the

diseases were very much easier to handle after that.

When I began practicing medicine in Nevada in 1929, we were using a tablet called APC—*aspirin, phenacetin and caffeine*. It was a throwback to old World War I army medicine, but it really was excellent for fever and for aches and pains, and we used it pretty generally until the introduction of sulfa, which was the first antibiotic that came to the area. APC tablets came in a large cardboard bucket that contained twenty-five thousand tablets. We bought APC wholesale because we had so many patients to treat. The phenacetin in APC tablets helped to reduce fever and pain, working synergically with the aspirin. APC was prescribed for flu or for the grippe, and for any pain such as arthritis...it was a generally used medicine at that time and a very common one.

Nevada has an environment that contributes to allergy problems, with sagebrush and all the different grasses and dry weather. When I was practicing in the Ely district, we treated hay fever and asthma and allergic dermatitis. And after World War II, as work came out on skin testing for allergies, we did our own skin testing and sent the results to the Cutter Laboratory in Berkeley, California, where we had the antigens made up for the patients' allergies. To treat the symptoms of allergies, we had antihistamines like pyrobenzamine and benadryl, and we had adrenalin injections which were used for very acute allergies. When cortisone came in, we used the injectable variety for the treatment of allergies, but cortisone was used sparingly because it had potentially dangerous side effects.

In the 1930s and 1940s we may not always have recognized that a patient had an allergy problem, and we would treat the patient for

the general condition rather than the specific need. In other words, if someone came in with a runny nose and we thought it was a cold, we treated it as a cold; whereas it could have been an allergic thing and would have cleared right up with the use of a couple of antihistamine pills. And the same with skin conditions: we treated them as an eczema, which was a blanket cover for any skin disease, but we used various types of ointments until we found out that we could clear them up with the oral use of cortisone and with the local use of cortisone, which cleared them up dramatically.

Josephine and I married on July 6, 1933, and the reception was at Dr. Hovenden's home. His wife had a wedding breakfast for us, but there were few guests. Following the reception we left for a honeymoon in Reno, which was a real delightful trip. I had one week off! [laughter]

Josephine needed something to do, but all the years that we were married she never did anything for pay; always, it was as a charity thing. She was particularly interested in acutely ill children, and innumerable times would go and spend nights with them and let the family rest. Josephine was a graduate nurse, too, and she would help us doctors occasionally, but she had two children to raise, so she was tied up pretty well. Of course, she had been superintendent of nurses of Salt Lake County Hospital, and she had been president of the Utah Nurses Association for two years, but once married she did only volunteer work, including Red Cross nursing. She trained all of the Red Cross nurses in the Ely district for years.

Life was pretty hard for women throughout the Ely district. It was a men's community, really, and I was busy a good part of the time in McGill, but Josephine's outside interests

kept her active. Three years after we were married Jo became pregnant, but we lost the first child in childbirth. Two years later she had Ann. Josephine was a devout Catholic, and we raised our children Catholic. Before my first daughter was born I converted to Catholicism, and I have practiced that faith ever since.

Social life in McGill was not that complicated. It was usually dinner parties and a bridge game or a poker game. Dinner parties were sometimes a disaster. Jo would get a dinner ready, and we would be having guests, but I would be out delivering a baby or helping with surgery, so she would have the party herself. Jo tolerated it very well; she understood, having been a nurse for many years.

At the end of the 1930s and the beginning of the 1940s, the United States was building up for the war effort. We were starting to be a very active industry, and we were working twenty-four hours a day, seven days a week. We had a full staff of doctors until the war broke out, and then we lost two of our doctors. In 1942 we were considered a strategic industry, but two of our men were in the reserve and were taken by the army. I had been in the reserve but hadn't been active, and I felt that I would like to join. My brother, who was a surgeon in Bingham Canyon, and I decided we'd try to get in the same outfit together. So I told the chief surgeon about it.

In April of 1942, I went into Salt Lake City to take my physical for the army, and they found that I had a perforated drum, which I've had since the age of four from an old mastoid infection. I also had had a duodenal ulcer in the 1930s, which was healed. I neglected to tell them this when I took my physical, but my chief had written to the commanding officer at Fort Douglas, and he had the letter in front of him. After I had taken my physical, he called

me into his office and asked if I'd ever had an ulcer. I reluctantly admitted to the fact that I had, so they xrayed me the next day and they found the scarring. The major would not turn me down, but he wouldn't pass me. He sent my papers into Washington for review, and six months later I found out that I was unacceptable for army duty. Needless to say, all of the men that turned me down are now dead, and I am still working hard! [laughter]

STEPTOE VALLEY HOSPITAL

The chief surgeon ran the Steptoe Valley Hospital, reporting to the general manager of the company. (The only person who had anything to say about health and medicine except the chief surgeon was the general manager, and he wanted the hospital to be the best because he came there for his care and his family's.) In 1943 the chief surgeon died and Dr. Walter Frolich, who was assistant chief surgeon, was made chief. He asked me to come over to the Steptoe Valley Hospital as assistant chief surgeon. I reluctantly accepted, because I had not been doing much surgery except for assisting; but I went over there and was in the swing of doing my own surgery within a few months, and I did that until I left in 1953. I also delivered most of the babies that were born, because we were short-handed. During those years, I often delivered forty or fifty babies a month, and it was really hectic. It was a very fertile community! They had a lot of LDS people, and they didn't believe in birth control; they believed in large families, and they had them!

Because of the war, we had regressed from an eight-man group to a four-man group. There was one man at the mine hospital at Ruth, and there was one at McGill at the mill and smelter, and two of us were at the Steptoe Valley Hospital. So it fell upon me to do all the deliveries, make all the house calls, and either do or assist with all of the surgery for Ruth, Ely and McGill for the next ten years. An average day was eighteen hours, and a bad day was twenty-four. I saw times when I went three days without any sleep. I stayed because there wasn't any place to go. [laughter] Well, this was our job, and we did it to the best of our ability. They finally got some help in from some other communities, but the war years were real rough, tough work days with nobody getting a day off.

When I transferred to Steptoe Valley Hospital I moved my family from McGill to East Ely, where the hospital was, and we lived on the hospital grounds. We had a real nice three-bedroom, brick house right across the street from the hospital so you wouldn't have to go too far when you got called. The hospital

would be full all the time with anywhere from thirty to forty patients. Since I had relieved at the hospital for vacations during the summertime when I was at McGill, I was used to the routine. I had also been called over lots of times to assist with surgery, so it was not greatly different from what I had been doing.

A lot of the young men went off to war, of course. Some of them, like the general manager's son, did not. They were considered to be needed in their jobs, which was not always quite true. [laughter] People resented that—they resented any of them who stayed whose fathers had executive positions there, and I don't blame them, because they were no different than any other boys. They should have all been taken. As a consequence of the war, the average age of the workers climbed a little, but not much. We had a lot of people who worked for many years for the company and were still working when they were fifty, sixty, sixty-five, so that part didn't change. What did change was that we didn't have that pool of young people in the summertime, when they would be put to work in the yards and wherever they needed them. But we got them from other places: kids from Utah and a lot of surrounding areas came out and worked. Interestingly enough the health profile of the work force did not seem to change during the war. Even the incidence of sexually transmitted diseases did not go down as the young men left. [laughter] It never seemed to change much!

During the war, when the Japanese were interned all over the country, our Japanese laborers were also interned. I felt real sorry for them, because many of them were good American families and the children were American-born and didn't deserve that kind of treatment. There were probably about

twenty Japanese families that were sent to the internment camp in California. Their departure was a very sad thing for the whole community. The Japanese children had been integrated into the schools, and they participated in athletics and everything. The community felt that it was a very unfair thing to do to them because they had been good citizens, and there was no sentiment for removing them that I ever heard. The management of the company was not for it and I don't think the people were, either. Nobody held any enmity toward the Japanese families there.

As to the actual removal, I can only recall that some federal people showed up and the Japanese were just transported out in buses. I am not sure, but I think that they left their possessions there to be taken care of later. I think the company took care of shipping a lot of their stuff down to California for them. After the war, the Japanese families apparently did not return to the Ely district, for we didn't see any more of them there. There had been a few Orientals in Ely running a couple of little restaurants, and they were moved out too. Some of them did come back to the restaurants, but none came back to work for Kennecott.

The company hospitals would treat people who were not members of families that were employed by the copper company. We treated anyone, including a good number of people from Ely and from the outlying ranches. In fact, Steptoe Valley Hospital would get patients from Pioche and Caliente and Eureka all the time. It was a medical center for the entire area. There was, however, a different price scale for those who were not employed by Nevada Consolidated Copper. Private patients paid \$2.50. Prices were low for everybody, but higher for private patients.

As physicians working for the Kennecott Copper Corporation in McGill, Ely and Ruth we also had an outside practice, and we would be called to outlying communities as consultants. I would go to Eureka, which was about seventy-five miles west; I would go to Pioche, Caliente, Baker and Cherry Creek to make house calls. I have delivered patients in farm houses in outlying areas; I have taken care of patients with illnesses as far as thirty miles from our office, with good practical help, and this was just part of the practice there. There were no doctors in Cherry Creek, Preston, Lund or Baker. There was a doctor part-time in Eureka, and there were doctors in Pioche and Caliente, but these doctors would call us for consultation, and there was hardly a month that went by that we didn't go one place or the other. We would take care of patients for them, and, if necessary, transport them over to our hospital at East Ely.

In those communities that had no physicians of their own, we would just see patients in their homes. There were no clinics; there were no places to take care of them. However, many times we would go out, and, having a little bit of the patient's history, we would take out medications that might cover the conditions that we found, so that they wouldn't have to come into town for medicine. If not, they would have to come into town, or if the patient was too bad we would send an ambulance. We saw a lot of outside practice that way.

When you went into the field like that, you would go alone as a single doctor. No nurses, no nothing most of the time; just yourself. If it were for an obstetrical case, you would take a nurse, but otherwise you would go alone. They finally got a couple of good doctors in Pioche, so we didn't have to go to Pioche and Caliente, but the medical coverage of Eureka varied. Sometimes they would have a good

man there and sometimes there would be no one. At Preston and Lund, nobody, and at Cherry Creek, nobody.

We were on call for the company twenty-four hours a day, but we could see private patients. I gave my private practice in town whatever they needed—three hours, four, five...depending on how much they needed. However, we always practiced on a first-come-first-serve basis. Whoever came into the office first was taken care of first, and whether they were unemployed or the general manager made no difference. As long as I practiced, ever since 1929, it's been that way in my office, and that made me somewhat different from most physicians. I never set up appointments for this reason: we didn't know whether we were going to be in the office or in the operating room or out after an accident or in the delivery room, so there was no use trying to make appointments. The population in the Ely district accepted that as a way of doing business. It had to be that way, because we couldn't say, "You be here at eight o'clock in the morning," and we'd be in the operating room doing surgery on something that had come in during the night.

Our private practice was right there at our emergency room office. It was just mixed in with our company practice, and we used the company facilities. We had to, because we had to be there. Our nurses were not paid separately for assisting in our private practice. They just worked their eight-hour shift, and even if they were assisting a doctor doing private practice, it didn't make any difference. It was all part of their job, and they were paid well.

The winter of 1948-1949 was a real winter! We had lots of snow, and roads were blocked. One day when the roads were blocked I had a youngster in McGill with an acute appendix, and having no way to

get him over to the hospital, we decided to do the appendectomy on the kitchen table... which is what we did. Dr. Hovenden gave the anaesthetic and my nurse helped me, and we did the appendectomy and had the child up in a couple of days.

The snow was really a hassle every winter. Many times a nurse and I would trudge through the snow to deliver a baby out in one of the neighborhoods where they hadn't plowed the streets. We would hike up to a house with our boots on, carrying the obstetrical bags and all of our stuff with us, and stay right there until the delivery. That happened almost every winter, but the winter of 1948-1949 was *particularly* severe. Oh, that was a real humdinger! It got down to about twenty below for about *six* straight weeks, and there was so much snow that they had to airlift hay to the animals. But we took care of our people.

I was made assistant chief surgeon in 1943, and finally, about 1948, I got my first month off. [laughter] But it was a very satisfying practice. During the war we just did everything. We would start rounds at six thirty in the morning, and at nine o'clock we'd start surgery. Whenever we got through, we would start office hours and we would run office hours until five o'clock in the afternoon. After that I would make house calls, then I would eat dinner, and then I would go back and have more office hours. Following the war, things let up a *little*, but we still always started rounds at six thirty and then if the rounds weren't too heavy, we would start operating at eight o'clock.

It was some time after the war ended before activity slackened very much, because there was a lot of copper used in commercial manufacturing. However, after the war they started cutting back and having two-week or

six-week layoffs to repair the furnaces and things like that. Those furnaces have to be shut down every once in a while to be relined. Of course, that takes about six weeks, so they would let the men have a vacation at that time. Even then, the days of the medical staff hardly changed. Things weren't quite as hectic, and we didn't run a night office when they were down, but we ran seven days a week, including Sunday mornings. Sunday mornings at the hospital the obstetrical cases and the babies would be coming in. We were on twenty-four hour call seven days a week.

I may not have been making as much money as I could have in private practice somewhere else, and I was working longer hours, and I didn't have much time off, but there were a lot of extras that were good: I was provided with a furnished office that was serviced by a nurse; my car was taken care of.... I had no expenses of doing practice. I was prospering; I was doing all right. Of course, I had a private practice in Ely, and I made more on the private practice than I got in salary from the company.

With all of the time that I was spending on the job, Josephine was the parent who was principally responsible for raising our family. She was in complete charge. Josephine didn't get pregnant again, so we adopted our second daughter, Susan, in April of 1943, and Josephine had to go to St. Joseph, Missouri, to pick her up. That was an experience! Due to the war transportation was really hard to get, and reservations on trains were at a premium. But she got there and got Susan and brought her home; Susan was two weeks old.

My being busy all the time really did not make a difference with the girls, because they had a wonderful mother, and they loved her, and she loved them. She did all of the disciplining of them. I raised two daughters and never struck one at all, so that's a pretty

good sign of control. Never once did one of my children get a spanking from me. They did from their mother, but not from me.

Life in East Ely was very nice, and we lived in a nice home. Our neighbors were the chief surgeon and his wife and two children; another assistant M.D., who had no children at that time; and the laboratory technician who had three children. The children grew up as good friends. Life at home was very easy-going. At the table we would talk about what the children had done that day; what they were doing in school when they got old enough to go to school; what they did with their friends. We always hoped that the children would eventually get a college education, and we worked with them for that future. Josephine and I were both avid readers, and the children seemed to pick that up. They are now about the same way we were: when you were sitting down you usually picked up a book or a magazine and read.

Reading went primarily in the direction of biographies and autobiographies and historical things...occasionally novels, but it became apparent to me that one novel was so much like the next that I stopped reading them, and my reading from that time on, and Jo's too, was more in history and music and art and sculpture and architecture, et cetera. The children, of course, read children's books, and we tried to give them what was accepted as good literature for children in those days. And I know we did.

At Ely the children's playmates were just the ordinary children of the neighborhood, and our daughters went to the public schools and the public high school. Susan was a very outgoing child and always had five or six children playing in the yard with her in East Ely. We had a nice big yard that the children used. We had a tree house which they loved, and life was very serene and uncomplicated.

For my annual post-graduate work I liked going to the University of California Hospital in San Francisco. I also went to Denver several times. I went to Salt Lake City and to Chicago, where I spent six weeks at the Chicago Lying-in Hospital and the Cook County Hospital in urology. Year after year, you do something, you see, because you have to keep up or else get out. The new things came so fast that you had to do something almost every year to stay current. The company paid for none of this. You did this on your vacation time. My colleagues in the Ely district were good students. We read a lot of the literature and we discussed it every two weeks, throughout the year.

Never once were we threatened with a lawsuit there. We must have been doing things right. There was never a question of "Why didn't you do this, why didn't you do that?" We were real careful about having another doctor see anything that wasn't going the way we thought it should. In other words, consultation was a constant thing. There was no jealousy about one fellow doing something and the other fellow not doing it. It was just a matter of cooperation all the way down the line with the doctors and with the help. And this was the way it has to be.

When I first started in the Ely district we used ether for anaesthesia, and then we switched to spinal anaesthetics and we gave our own spinals. On our own, we learned through reading and study how to do spinals and how to monitor the patients. After than all of our patients that had surgeries from the nipples down were given a spinal anaesthetic, and the only time we used ether was when we did tonsils and thyroids.

Occasionally we would run into trouble with anesthesia. If you do spinals, you have trouble with spinals; if you give ether, you

have trouble with ether. The only doctor who does *not* have trouble with any surgical procedure or any medical procedure is a man who never does it. In Ely I once lost a child who had been readied for a tonsillectomy, and who died from anaesthesia. I was grateful to God that I wasn't giving the anaesthetic that day. The physician who did it was just broken up, but he was all right after a few days. It was not his fault. If you give them anaesthetics, you stand a chance of losing them.

My daughter Ann had pneumonia when sulfa was introduced in the early 1940s, and she was the first patient in the White Pine County area to receive it. Of course, we didn't really know how to use it. We gave her very large doses and she became very cyanotic, but in twenty-four hours she had no signs of her pneumonia, and in about two or three days she was up and about with the quickest cure of pneumonia that I had ever seen!

Politics was an interesting feature of life in the Ely district. The officials and most of us who were involved in supervisory positions were registered Republicans, and most of the laboring people were registered as Democrats. This was really a pretty typical split of the haves and the have-nots. The haves were Republicans; the have-nots were Democrats. And, of course, the Democrats were an overwhelming majority. We were visited frequently by Nevada's senators, representatives, and the governor, because we were the second most populous area in the state at that time. It was interesting to meet with people like Senator Key Pittman—who was high up in the U.S. Senate—and Patrick McCarran, who was also a high-ranking senator, and with Representative Walter Baring. All along the line these men would come and have breakfast with us and tell us their stories.

I never did believe Senator McCarran very much. Once there was a bill coming up in the Senate regarding medical problems, and we talked to him about what we felt was the right thing for him to do. He assured us that he would see that it was passed, and when the votes came out, why, he had cast one of the negative votes that defeated the bill! So we learned not to listen to these fellows; we listened to them, but we didn't believe most of them.

Among the politicians who visited the Ely district, Senator Key Pittman was probably the one that we respected the most. You could bank on him. If he told you something, you could be assured that that was the way he was going. Of course, he was not involved in medical bills, but he was interested in bills that pertained to mining, which was our life blood; and he was real good to us. Representative Baring was an excellent person too. He was a great man, and probably one of the most honest people that I ran into. Of course, we had governors in all the time, and two of them were men whose families I took care of in the Ely district before they became governors. Those were Governor Vail Pittman and Governor Charles Russell. We were having dinner with Vail Pittman one night, and he was decrying the loss of an election. He blamed it on the fact that his opponents in Las Vegas had paid off the voters of the Westside to vote against him and for the other man. (This had to be in the 1940s.) Pittman was so upset because he had offered half as much as the other fellow did. And, of course, the voters went with the bigger deal. [laughter] This was the way politics was. The Westside was real money-minded; selling votes was not an unusual thing.

In one of the elections—and I can't remember which one—my colleague and I decided that we would take all of the home-

bound people down to vote, because it was impossible to get absentee ballots for them at that time. So we spent the day hauling old people and patients down to the polls, and in that election we were beaten by a bigger majority than ever before. We soon quit doing that. Republicans were much in the minority in the Ely district. We thought by taking these people down we could enhance our position, which we did not do. That was the only time and the last time that we hauled voters to the polls. [laughter]

Turnover of company doctors was very slight. Dr. Bowdle, who came in 1916, stayed until he died in 1943; Dr. Hovenden, who was the second man, came after World War I and stayed until he retired at about seventy-five years of age. Dr. Frolich came probably in the late 1920s and stayed until 1954. The only turnover was in a few of the younger men that we had. During the war years a couple of the men went into the service and didn't come back, but one did. Although some of the nurses came through and then moved on to other positions, many of them stayed and married there and continued as part-time help, so that we had a full staff of nurses all the time. In 1953, I decided to leave.

In Ely, and especially in the company towns of Ruth and McGill, society was just like the army. You were at a level, depending upon your education and your salary, and your family was at the same level you were. If you were a day laborer, you had certain privileges; and if you were a mechanic, they went up; and if you were a doctor, you got more privileges. The social life was on a similar basis—it was just absolutely segregated at different levels. As the children were growing, we advanced in the echelon of doctors. When I became assistant chief surgeon and was transferred

from McGill to East Ely in October of 1943, the social obligations increased. Having come up another notch in the social ladder, we were invited to company functions that were put on for the executives that visited from New York City and from Salt Lake City.

At a dinner party in 1953 the chief surgeon's wife, who was very peculiar at times, started to get after me about my wanting her husband's job and his house. The general manager's wife was sitting at my right and the attorney for the company was across the table from me. (That was a big party of about seventy people for the company.) And I thought, "Gee, this is a good time to quit." I looked at her and said, "You know, Marie, I don't want your husband's job and I don't want his house and I am going to tell the general manager that in the morning." And that is when I resigned. You could have heard a pin drop in the room. After I finished my dessert I went over to Jo and I said, "I just quit."

She said, "Oh, OK!" [laughter]

Then the hubbub started. We left the party and I went over to the hospital and typed out a resignation and made several copies, and I put the original on the chief surgeon's desk and told the girls at the office, "I won't be here in the morning. I am going over to McGill," which was eleven miles away. I took my resignation over to the general manager and handed it to him, and he said, "What is this?"

And I said, "My resignation."

And he said, "Oh! You meant that last night!"

I said, "Yes, I did."

He said, "I'll be getting in touch with you."

So I went home and went over to the hospital and scrubbed up and did my surgery and saw my patients. I gave them six months to replace me, because they had a hell of a time getting men. That was probably on a Saturday

night, and a day or two later the chief surgeon called me in and with tears in his eyes said, "I can't control my wife and what she said."

I said, "Walter, I don't believe that, because you put her on to a lot of these things,"... which he did. And I said, "I don't believe that, because I *can* control my wife." The general manager called me over in about a week, and he said, "Would you take the chief surgeon's job if we let Walter go?"

I said, "No, that isn't the answer, John. That isn't what I want." After a very successful practice and a lot of happiness, I just wanted out.

Ely was a good place, and the company provided security. It was like a family, and you knew that no matter what happened you would have this salary every month. If you were sick, it didn't make any difference; if you were on vacation, it didn't make any difference: that check came every month, just as regular as a clock. And all of your amenities: the house, the electricity, the heat, the yard work...all provided. All I had to do was buy the car; they even put the license on. They bought all my liability insurance. It added up, and in those days you didn't have to count the benefits as part of your salary, so you had no income tax on them. The only thing you paid income tax on was your check.

Life as a company doctor in the Ely district was a real good deal financially, and but as I look back on it now, I might better have stayed for two years and then pulled out. I don't think I would let a son of mine take a job like that, because it was *too much* like living in a family. You should get out on your own, but, of course, I had no problem. I stayed twenty-three years before moving to Reno to start a new practice in 1953.

LIFE AND PRACTICE IN RENO

When I arrived in Reno in the summer of 1953, we were experiencing an epidemic of anterior poliomyelitis, and I was fortunate enough to be chosen to work on the team with the polio patients. Of course, I had two children of my own, but I never had been one to think that I would bring anything home or get anything when I practiced.

During that time, I think I'm the only physician who delivered a polio patient who was pregnant. She delivered on what was called a rocking bed, because that was the only way we could keep her breathing while we had her out of the iron lung. On that rocking bed, I delivered a breech baby for her. I think it's the only obstetrical case that was delivered of a polio patient during that epidemic, and it was an experience that I will never forget. About twenty of my colleagues, including a couple of the obstetricians, stood around the sides of the room laughing while I delivered this woman of her child on the rocking bed. They were amused because it was a breech delivery and I had to synchronize my moves with her movement on the bed. It was a

touching experience, but she got a nice baby and eventually went home from the hospital with it.

The rocking bed had been developed for people who had respiratory troubles where there was diminution of the breathing space. It would allow them to breathe much easier than a flat bed. We were fortunate enough to have one at Washoe County Medical Center (Washoe Medical Center since the mid-1960s) at the time the epidemic began, and we used it with polio patients who did not have to be in an iron lung twenty-four hours a day. The change in position would keep them breathing. Putting the pregnant patient in this was the only way that I could see to handle this obstetrical case successfully. The head would raise; the foot would lower; then it would reverse. It would keep that up at a rate of about twenty changes a minute, going along with the respiratory rate, an electric motor driving it. We had to improvise this procedure, and I haven't seen it in use again.

During the epidemic, the men who worked on the polio teams were surgeons

and respiratory specialists and general practitioners and internists. The patients were monitored for all of their needs, and were given *excellent* care. Occasionally, one would have to have a tracheotomy tube put in because of the tremendous amount of mucous that they had in the trachea, and the surgeons would do that...or if it was an emergency, whoever was there would put a tracheotomy tube in. Our results with our polio patients were very good. It was at the time when the Sister Kenny treatment for paralysis came out, and our nurses were sent there to learn how to use the packs. Generally speaking, we sent our patients out with a minimum of permanent paralysis.

The polio team was put together by the chief of staff at the Washoe County Medical Center, and volunteers were asked to join it. Some of the other physicians who were on it were Dr. Fred M. Anderson; Dr. Frank A. Russell; Dr. John W. Brophy; Dr. William A. O'Brien III; Dr. John G. Scott, Sr.; Dr. William E. Simpson, Jr.; Dr. Emanuel "Bud" Berger, the pediatrician; Dr. Jim R. Herz; Dr. Fred D. Elliott.... We did not have regularly scheduled hours during which we were on duty as part of this polio team, but all of us would make three or four visits in the twenty-four hours of every day and night to see these patients. If you were there on an emergency at midnight, you went in to see how they were all doing. And there was no real division of labor among us. We all did the same types of things, and we worked as consultants for each other. If any patient got in trouble, whoever was there took care of it. It was a group effort, and it was a good one.

It was after our epidemic that Dr. Jonas Salk developed the polio vaccine, which was a godsend. We started giving it as soon as we could...we gave it citywide. We started first with pre-school children, and then

school children, but we gave it to everybody. The effort was handled by the county health department.

Part of the reason for moving to Reno was that Jo and I felt we had stayed in the Ely district long enough and it was time for a change, particularly for our two daughters. We had hoped to leave by the time Ann was ready for high school, but she finished her first year at White Pine County High. We came to Reno with the understanding that Dr. Walter Quinn, who had been part of our staff, would come along with me, and we would start an office in Reno about the first of July of 1953. (In the event, Dr. Quinn was not to arrive in Reno until two years later.)

With that in mind, we purchased a home in Reno and also an office. Dr. Rodney Wyman, who had been a surgeon, had walked out of his office a year before on a Saturday at noon, and by two o'clock he had died of a heart attack. His office was empty, and this was what I started out in. I picked up a good deal of Dr. Wyman's general practice. However, by then much of his practice had been disseminated amongst the doctors in town, which was a logical thing, because people needed a doctor. Of course, there were also a lot of people from White Pine County who had moved to Reno, and I started to see these people. Soon I had a practice that was almost too large to handle. We opened the office about the middle of August of 1953, and by Christmastime I was working eighteen hours, seven days a week.

The ratio of doctors to population in Reno in 1953 was very low. There were not many general practitioners. There were excellent specialists in surgery, obstetrics, orthopedics, pediatrics, et cetera, but the general practice field was wide open for any number of men that could come in at that time. I got a good

reception from the hospitals and from the medical people here, and it was easy to start a practice.

The office that we bought was at 729 North Virginia. (That space eventually was taken over by the freeway, which was a sad situation, because we had developed a nice office building there through the years before the freeway extension was planned.) Our medical office had no name; we didn't even have a number on the building. The Post Office Department came one day and said that if we didn't put a number on the building they were going to quit delivering the mail there. We finally put 729 on it because of the post office...but we were just Smernoff and Quinn, and that was all. Then when we moved down to the Ralston Street location, it was Smernoff, Quinn, Glenn and Inskip. It has always been that way, but today they do call it the Ralston Medical Office.

The practice developed into almost a horrendous thing, because I had so many people referring patients to me. When I first came I was doing my own surgery, my own obstetrics, and my own orthopedic work, because I had done all of this in Ely for so many years. As the practice developed I let the surgery go and then the orthopedics, but I kept most of the obstetrical practice. The practice within a year was really more than I could handle, and Dr. Quinn had gotten tied up with some real estate in Denver and couldn't join me in Reno. After two years, I decided I just had to have someone come and help. A young man who was working at Stead Air Force Base and doing relief work at Washoe County Medical Center finally agreed to go in with me. The day that I got him to acquiesce, Dr. Quinn called and said he would be out the next week, so I had to ask the young man if he minded if I backed out. He said no, that he really preferred to do a residency in internal medicine anyway.

While Dr. Quinn was in Denver, he did some postgraduate work in surgery and was accepted into the American College of Surgeons, so he was a well-qualified surgeon; but he was a good general practitioner too. When he came, the office didn't get any quieter; in fact it got worse than ever, which is what happens when you bring in a partner. You really don't get any relief; the thing just gets worse. The first one keeps his practice and the other one develops a practice of his own, which is only natural. Eventually we had to start getting other men. Dr. Gerard E. Glenn was the first to join us, in about 1965, and then Richard C. Inskip and then Raymond Mann. Later Dr. Gene A. Llewellyn joined us and left, then Dr. Jay C. Chamberlain arrived and Dr. Brian J. McCormack and Dr. Thomas D. O'Gara. Dr. Mann retired in 1989. That's a lot of doctors. (Dr. Chamberlain graduated from the UNR Medical School in 1973, and Dr. O'Gara in 1984.) It's been the busiest office in town and still is, and it was a walk-in practice right from the very first day; no appointments, ever.

When Walter Quinn came in, he came in on a full partnership basis because he and I had worked in Ely together. I owned the building at first, but when we built the new building I let Quinn and Jerry Glenn come in with me as partners in the building, and they paid their share of it. After Dr. Inskip had been here for about five years we gave him a share of the building, and the four of us still own it. The doctors came in on a salary for the first year, then a percentage in their second year, and then a full partnership in the third year. By the time they got their full partnership, we also included the equipment in the office in the partnership. It worked out great for us. They were happy and we were happy.

As far as recruiting went, we got Jerry Glenn from Nebraska and Inskip from back

East. Of course, Dr. Chamberlain was an Ely boy. Dr. Quinn delivered him, and I used to take care of him when he was a little kid over in Ely. Now with the University of Nevada medical school in Reno, these boys show up. We have two excellent boys in McCormack and O’Gara; O’Gara is a Reno boy.

The first nurse that I hired in Reno was Mary Cael, a girl who was born in Cherry Creek. I knew her as a kid. And my first bookkeeper and office girl was Lillian Elliott, the sister-in-law of Russell Elliott, whose family were friends and patients of mine in Ely. I had known Lillian since she was five years old.

As the partners came in, we had to expand the nursing staff and the office help. Bernice Lawson was the next nurse we hired, and then Charlene Gasho was added to the office staff. Now there are about eighteen girls in that office. There were about fifteen when I left, but only five of us doctors. The paper work has gotten to be absolutely horrendous... absolutely horrendous! With the nurses in the office it was the same thing as it was with the doctors: when they came, they stayed.

When I arrived in Reno, Fred Anderson—a general surgeon who had done a lot of general practice before and after the war—asked me if I would assist him with some of his surgery. This I was delighted to do, because he was an excellent surgeon. In this association I would go with him and assist him in Fallon, and I would go to Carson City and assist him when he had a case there, and I would assist him here in Reno. He and Frank Russell were working together a lot, and I met Frank Russell and also assisted him. He was also an excellent general surgeon, so that as I got busier and I had heavy schedules I would ask either Dr. Fred Anderson or Dr. Frank Russell to do the surgery. If I could, I would assist,

and if I couldn’t, they could get someone else. We had a very close association from 1953 to 1955. In 1955 Dr. Quinn, my associate, arrived on the scene. He was also a board surgeon, so from then on Dr. Quinn did all the surgery for our office, but I would still go out and assist Fred and Frank occasionally.

During my first years in the Ely district I got a tremendous number of traumatic cases, but by the time I left it had become a fairly decent place to work because they had become conscious of safety and first aid. So the practice in Reno was not greatly different from what I left in Ely, except that after Quinn came I didn’t do much surgery any more. The thing that really drove me away from surgery was the tremendous waiting period. You’d go over for an eight-thirty case, for instance, and maybe get started at ten o’clock. Well, that meant that for over an hour you sat around on your behind in the doctors’ lounge waiting for your case to come up. I couldn’t take it—that wasn’t my dish of tea. I was better off to be where the people were and I could do what I wanted to do.

Dr. Bill O’Brien was elected chief of staff of Washoe County Medical Center shortly after I arrived in Reno. He had one vacancy to fill on the executive committee, and he invited me to join them. I was reluctant to do that because I was new in the community, but he was insistent, so I accepted the appointment and served for a year, following which I was elected secretary of the staff. I served for a total of ten years on the Washoe County Medical Center executive committee, from 1954 to 1964. As secretary I had to keep the minutes of the monthly staff meetings and also the monthly executive board meetings. It was an interesting experience, because it gave me insight into the regulation of the practice of medicine in Washoe County. We tried very

hard to take care of any problems that arose between the medical staff and the hospital employees, and the staff and their patients. Straightening out the problems entailed quite a bit of extra time, but it was a worthwhile experience.

Disputes were settled by a meeting with the doctor and the patient who was complaining of the treatment that he had received. From there, complaints were sent to the doctor-lawyer committee to decide whether there should be an action taken or not. The doctor-lawyer committee was a group of doctors and lawyers who screened any possible litigation between the patients and the doctors. This probably was the beginning of the medical-legal panel for screening medical liability cases, and this has gotten to be a very important factor in the medical and legal communities in Washoe County at this time.

The doctor-lawyer committee was a standing committee that apparently had been in existence for some time when I joined the staff. We enhanced it and enlarged on it. When any problems arose, the executive committee tried to settle them without any notoriety or any outside people, except the ones actually involved in the problem. And it worked very well. We also policed the staff. This is true of any executive committee in any hospital: they police the staff, and they see that doctors practice medicine which is up to accepted standards. They try to keep problems from arising by policing their doctors and being sure they are trained for the procedures that they ask privileges in. If they are not, they are not given the privileges. And if it is found that a doctor is exceeding the privileges which he is granted, he stands a good chance of being expelled from the staff, which means he cannot bring any patients into the hospital.

We had some real tough policing problems. One physician in the 1950s was doing hysterectomies, and two of his hysterectomies were on pregnant women. They were essentially abortions; that's exactly what they were. He was doing abortions, but doing them in a very sophisticated manner. This was much against the rules of the hospital, so he was put off of the staff. Then we had doctors who would extend themselves doing procedures for which they were not really well trained, such as a surgeon who was doing bowel resections who had not had enough training. We had doctors who wanted to do complicated obstetrical procedures that they were not trained for; they were not allowed to do that. We had a man who was using hypnosis and then sexually abusing his patients. He was fired from the staff without any question.

In the case of the surgeon who was doing the hysterectomies, and a fetus would be found at the laboratory, it was pretty hard to point the finger and say, "You're doing abortions!" Uteri have been removed by excellent gynecologists, and a pregnancy has been found. So it would *not* be a case to be pointed out to the State Board of Medical Examiners, but it *was* an ethical problem with the hospital. But any infractions that were of a legal nature were turned over to the attorney general's office. That included the GP who was hypnotizing female patients and then taking advantage of them sexually. That was turned over to the district attorney, and he was taken care of by them. Any infractions of the law were turned over to the Washoe County Medical Society, and from there to the district attorney's office, but purely ethical questions were handled by the executive committee themselves.

General surgery was the main source of problems. Some family practice men would

get into trouble; the fellow who was doing hypnosis was a general practitioner. By the time specialists had three years of their specialty, however, you usually got pretty well-trained men, although I can recall one chest surgeon who came in, and his chest surgery was not up to the standards of the community, and he was taken off chest surgery cases. Since most of the problems involved men extending themselves and doing procedures that they really weren't trained to do, we finally insisted that before a man was given permission to do a procedure, he had to be watched in three or four cases by a man who *was* trained in that procedure, and if he proved capable, he then would be given the privileges. If he wasn't really adequately trained, he never received these privileges. Once we began doing this we found that the incidence of this type of problem diminished significantly.

Perhaps of greater importance, we became much more sophisticated at reviewing a doctor's application before we gave him privileges. However, I think the kind of practical review we demanded would still be useful today and may still be done, even though a man's record is established and he is checked out before he even comes on the staff. He has either had a residency or special training in the procedures that he is asking permission to do. Now it is purely a matter of reviewing the application and deciding; that is a far cry from what we were dealing with in the early 1950s and 1960s. The credentials that one might present then were not as revealing or as strict as they are now. We were *very* much more lenient. When I first came to Reno, as long as you graduated from a Class A school and had a license to practice, the hospital let you do almost anything you said you could do. But as the procedures became more sophisticated and people became more highly specialized, it was

easier to screen them, because we knew if the man had trained for three years in ear, nose and throat, he would know those procedures or he could never have gotten his degree or joined his board. I think that by the mid-1960s this problem had been pretty well addressed at the Washoe County Hospital, but in the 1950s all hospitals were having problems. From news reports I recall that men who never saw a medical school were going into hospitals and doing surgery. The worst times were whenever there was a war or we were involved in a conflict somewhere. When a lot of doctors are called into the service but communities are anxious to have doctors, they aren't quite so fussy about their training. This is true in any time of stress for the nation. But at the present time and for the last ten or fifteen years *at least*, the people coming into the Reno area have been *well* trained and very capable in their work.

The executive committee also addressed some problems that were not related to medical credentials or competence. We didn't have much of a drug problem at that time, but we did have an alcohol problem, and that was addressed by the executive committee. Alcohol has always been with us. Doctors have always imbibed, and doctors who were alcoholics were operating, and these problems were taken care of. They were asked to get help through AA or some type of supportive treatment. They were not banned from the operating room, but they were watched closely so that they weren't admitted to it if they seemed to have been imbibing.

The alcohol problem among doctors here in Reno was no more or less extreme than elsewhere; it was pretty much the same all over the country. Problems exist wherever you find a group of doctors. They are humans, and they have the same failings that anybody else has. The pressure of a heavy workload; the

stress, perhaps lately, of living with the threat of a malpractice suit; the stress of having made a mistake, maybe; family problems... all might cause physicians to drink. I think that generally medical people are under a lot more stress than the average citizen who is in business or teaching or almost anything else.

The stress of having lives at stake every single day is *much* heavier than any other stress that I know of. However, I can say that in all the years that I practiced medicine, I never took a drop of alcohol if I was on call. That was my pledge from the time I got my license until this present day: I would never have a drink if I knew that I was on call and would be seeing people.

One reason I did not drink was that I had such a heavy workload. In White Pine County the load was heavy; but here in Reno, after I opened the office in 1953, my average would be from seventy-five to eighty patients a day, which included house calls and delivering babies, a heavy load in the office, hospital rounds twice a day, and usually sixteen- to eighteen-hour days, which would be sometimes seven days a week without a break. That's a real heavy load, and one's family suffers from a practice like that.

One wonders whether it would be better to have more doctors and give them more time off and let them make less, but I don't think most doctors would like that. Some doctors *do*: I know of two surgeons in Reno who used to limit their income to a certain amount a year, and when they achieved that, they took the rest of the year off...or they took enough time off so they limited themselves to a certain income. They put a limit on how much work they would do, and I think maybe theirs was the wisest way of doing it.

You can't ask the men to have more doctors come in, because they all feel that

they're worth more than anybody else. They've spent a lot of time and money in their training, and when they see an executive of a business making millions of dollars a year, they think, "Gee whiz, I'm as good as he is; why don't I make that?" But they never do. The worst-paid doctors that I have seen are the pediatricians; the next are the internists, and then the general practitioners. The specialties, of course, were always the highest-income group, and still are. They make good money, and they could stand a little less, but I don't think they'd be happy with less; and I don't think they'd be happy with less work.

After I'd been in Reno about a year, I was asked by the federal marshal if I would accept the position as federal physician for Washoe County. After some consideration, I accepted that job, and one of the most interesting things that happened to me as a consequence was that I became the physician for LaVerne Redfield, who was probably one of the wealthiest men in Washoe County. At the time he was in jail for income tax evasion. While in jail, Redfield developed an acute myocardial infarct, and I had to hospitalize him at the Washoe County Medical Center. I took care of him there, and when he went back to jail I continued to take care of him. When Redfield was released from jail he asked me to be his family doctor, which I remained until the time of his death. Here I was making about sixty dollars a month as the federal physician, and I was taking care of the wealthiest man in Reno for free! [laughter]

I was federal physician for ten years in Washoe County. My responsibilities required that I make calls at the Washoe County Jail on any sick federal prisoners, and if they were hospitalized I would take care of them. The position was offered to me by the federal marshal; there was nothing competitive about it. I don't think anyone else wanted it anyway.

The government was looking for someone to do it, and I knew several people who were in the FBI, and a lot of people around the various police departments, having met them as patients and at social events. Reno was small then—it only had about thirty-six or thirty-seven thousand population—and I think as the government looked around for a doctor, other doctors who didn't want it would probably mention my name as one who would take it. I was the new kid on the block.

The county jail was where all the federal prisoners were held until they were transferred. They provided a room to examine the prisoners in, but it contained nothing except a table and a chair. They had tape and dressings and bandages, but nothing else. Medications were brought in from a drug store, and I brought all my own instruments.

Today one hears a lot about bad health conditions within the prison system, but I did not have to contend with that. I took care of all the federal prisoners' physical needs, but it wasn't too strenuous a job. Back then the prison population ran about the same percentage of acute illnesses as the regular population—it was normal. And, of course, at that time we didn't have all the addicts that they have today, so it was a relatively easy and simple responsibility, but it was interesting.

In the group that we had in the mining camps, emergency care was no problem. Every doctor was called for any major emergency, and we had an ambulance and we had all of the things that you needed. We were the only people who took care of them.

When I moved to Reno, there were emergency rooms at both St. Mary's Hospital and the Washoe County Medical Center. The emergencies were all handled by the hospitals' staff doctors. When there were day emergency cases, doctors were just called

from their offices to take care of them, but at Washoe a doctor was on duty in the emergency room every night, from eight o'clock until seven o'clock the next morning. This was done on a rotation basis among the men, one night a week, except when a doctor would ask you to cover for him. I slept on a cot there many a night. St. Mary's did not have a doctor on duty at the emergency room at night. The emergency room nurse would admit a patient at night, but she would have to call a doctor from his house to care for that patient.

As time went by the emergency rooms got larger, and the hospitals hired doctors to work in the emergency rooms. They would take care of emergencies and would call you for your own patients. If you desired, you would go down and take care of the patients yourself, or if you didn't want to go down, they would take care of the problem or refer it to a specialty in which the patient belonged. The emergency rooms in both hospitals are now really outpatient departments. They take care of everything from head colds to ingrown toenails, and they have become just medical offices. Of course, emergencies that are *real* emergencies continue to be brought in, and their family physician is supposed to be notified, but he usually refers them to a specialist. So the care of the emergency patient has been taken over by emergency rooms and hospitals, and is not done by family physicians like it was in the past. When I first came to Reno, the physicians in our office would see every case of theirs in the emergency rooms, twenty-four hours a day. Then it became easier for the men to have somebody else see them, so eventually it has gone the way all of the other offices have, and now you rarely see emergency cases out of an office.

The nature of the modern emergency room evolved from the fact that there were so many people coming in that it became a

financial bonanza for the hospitals. When we first had emergency rooms, any patient who wasn't really an emergency was told to go see his family doctor the next day. This was if the patient came in at night. Daytime was easy, because the family doctor would be called, and if he wanted to come down, he would see them. But at night, real emergencies were the only thing that we took care of. Anything else went to the doctor the next morning. This practice changed because it looked like a good place to make money; the hospitals found they could make money by staffing emergency rooms and taking care of these patients.

(I may be off base by saying this, but this is the way I feel about it: it had to be on a money basis. Everything people do any more is based on the dollar, and medicine's getting to be the same as any other business. All medicine now is based on how much money you can make out of it, and I think the hospitals are as bad as the doctors on that score. In spite of the fact that the hospitals say they're going broke, they all seem to have high executives that make good salaries.)

When we came to Reno in the early 1950s, there was no identifiable part of town in which physicians and their families resided. Now, of course, the doctors want to live in big houses isolated from the rest of the community. So they live up in Lakeridge and other places where they can build a big house and be away from the community. But most of us were just in ordinary neighborhoods. Doctors lived on both sides of the tracks, on both sides of the river. Doctors lived in just any neighborhood where they happened to buy a house. But it's changing, and they don't want to live in the ordinary people's community any more. They seem to want big, isolated homes.

Our social life in Reno was entirely different than it was up in the mining

community, because here we were not part of a company, and there was no stratification. We made friends, and the transition was very easy for us and for the children, because several of their friends had also moved to Reno. We were members of the Our Lady of Snows parish, so we met a lot of people there, but we also met a lot of people through my medical connections. A lot of my patients were friends as well as patients, and we socialized with them a lot.

The family tolerated the move to Reno beautifully, and they were very happy to be here. In fact, the children to this day insist on owning a piece of property in Washoe County. They want a piece of Nevada, and I'm proud of that, because I'd like to have them have a piece of it.

Susan was enrolled in Our Lady of Snows parochial school and Ann chose to go to Manogue High School, which was also a parochial school. The only difficulty was that Ann was a straight-A student, and, of course, was snubbed as being a "brain" [laughter], and that really beat her down socially. She didn't seem to fit in with too many of them because she got good grades and they didn't, and they didn't accept that, which was rather strange, but that's the way it was in those days. When the children were students in any grade, there were only two requisites that I made of them: that they should behave in class, and that they should try. The grades that they got were immaterial. They *did* get good grades, but I think it was due to the fact that they worked and did their homework.

We felt that the children should decide for themselves in which direction they should go after they graduated from high school. Ann chose to be a nurse because of her mother, and she became a graduate nurse with a master's degree in nursing also. She also chose to enter a convent after her senior year. After

ten years in the convent, she decided that was not what she wanted to do, so she came out and went to work in nursing. The next year she was married, and she has three children. She continued her education in nursing and became associate professor of nursing at the Pasadena City College.

Susan was a gregarious type who did good work; she was a B-plus student and a real go-getter in social work in high school. In Susan's junior year we had a girl exchange student from Bolivia for a year in our home, and in her senior year we had a girl from Belgium. After graduation the Belgian girl's family wanted Susan to come to France and go to school there for a year, which she did. Physicians' children probably have a few advantages, primarily due to the increased income and secondarily to the fact that their parents usually consort with people with college educations—lawyers, doctors, engineers, and other highly-trained people. That was true over in Ely, and when we came to Reno, we socialized primarily with the medical profession, the law profession and the teaching profession, and I think that rubs off on the children a little bit. They may have been treated with a little more respect than they would have been otherwise, and maybe given a few advantages that we didn't pay any attention to at that time. I grew up in an entirely different environment. Ours was an environment of trying to survive, and my children grew up in an environment of having a few more of the things in life than we had.

In the 1960s I thought that the development of a medical school at the University of Nevada was a good idea, and supported it financially; we doctors all did. Of course, the big thing was the Howard Hughes estate giving us several million dollars and then

the legislature appropriating money for it. Then the doctors worked hard at collecting money to get the school started. I think that the whole medical community joined up. The county medical society always had a political action committee which was active in the legislature as it met every two years. Of course, it was only anxious to see laws passed that benefitted medicine and did not degrade it. This is true of any action committee; they have a very definite thing that they're going to do: they're going to help their group or their profession or their business or whatever.

The School of Medicine has had a great impact on medicine in this area. They brought in a lot of highly specialized people, which helped; they have graduated a lot of wonderful young people who are practicing medicine in Reno; and generally, I would have to give it a triple A rating. It's just great, and I'm glad we have it. I think it takes up some slack that we might have experienced had we not had it. We've gotten a lot of good doctors because of it. Otherwise, all over the state, we might have been a bit short of doctors.

In 1978 I had been in practice for fifty years, and I wanted to have more time for myself and to be with my family. It was nice to think about letting up and getting away from the pressures of a busy office, so I retired; however, it ended up that I still do some practice. The first year after my retirement I worked half-time, and after that I did less and less until at present I just see patients in the nursing homes. I go to the seven nursing homes in the area once a month and see all of the patients that the Ralston Medical Group has, and I also see them in between times. I see people in their homes who can't get to the doctor or who have a problem, and I make four or five house calls almost every day. Some of these patients are old friends

that I have taken care of for forty or fifty years. And as I tell them, they've known me long enough...by now they should be able to get a *good* doctor. [laughter] Medicine was my second love, and after I lost my wife Jo, medicine was the thing to fall back on.

I retain a share of the Ralston Medical Center building, but when I retired I got out of the clinic and after that was a salaried employee. I have not participated in the running of the clinic at all since the day that I retired, nor do I put any patients in either of the three hospitals. That I don't want to do, because that entails so much book work and so many charts and so many small, little things. I will visit patients in the hospitals, but not as a doctor, only as a friend. If I have patients that must be hospitalized, I turn them over to the Ralston Medical Group or to whomever else they might want.

I did my last delivery after I had retired, probably about 1982. The only reason that I went down and did it was because they couldn't find the man on call. That was the damndest thing. They couldn't find the doctor and they called me from St. Mary's and said, "We need a doctor right away." The woman was having her first baby. She was using the Lamaze method; her husband was with her; and I had never seen her before. The head was crowning already, and the nurse said, "Change your clothes and scrub. That's all you've got time to do!"

I went in, and it was the most normal, beautiful delivery you ever want to see. The woman did not speak and she never had any medication. I injected the perineum with a local and did an episiotomy and delivered the baby. Then she said, "What is it?"

I said, "It's a boy."

And she said, "Can I touch it?"

And I said, "Yes, you can."

Those were the only words that were spoken in that delivery room that day.

There had been a large number of women in the delivery room when I arrived, and when I came out and took off my gloves, I looked at the nurse and said, "Don't ever do this." I said, "What is this?"

She said, "It's about time these people got to see a normal delivery. All these deliveries, with their forceps and their spinals...we knew you wouldn't do that. So we called all these gals, nurses and nurses' aides to watch a normal delivery." That was my last delivery.

So many doctors were using forceps to deliver babies, but I always felt that Mother Nature did a hell of a lot better job than I did. We don't need all that stuff; you just can't get in a hurry. Mother Nature takes time. It took nine months to make that baby; you don't need to deliver it in five minutes. It will come out all right. Most women will deliver if you just leave them alone. I've preached that all my life, and I never lost a mother and I never lost very many babies. I was ready for Caesarians or forceps when they needed it, but the average mother doesn't. Doctors today do so damn many Caesarians it makes me sick, but they're afraid if anything happens to the baby in a hard labor they'll get sued. That was awful to have that hanging over your head. You know, to practice medicine and think all the time.... God!

The Lamaze technique trains the mother and the husband about what labor is like and what to do: the breathing exercises, the pushing, and all of that. When the Lamaze method first became popular in the 1960s I was all for it, because I believed in it. I was doing a lot of home deliveries where we couldn't give a lot of anaesthetics, and we had to do it on a breathing and relaxation cycle. Having a baby is not a disease. It's a normal process. But women are so scared; they

become so tense that it just hurts like hell. If you can take them and go through the Lamaze or any type of training like that they'll do a lot better and take a lot less anaesthetic.

We used to use a similar method fifty years ago, so this is not new. But when Lamaze became popular in the 1960s, we found that mothers using the method gave birth more easily than they had before. No question about it.

The thing that makes birthing hard is that doctors are in a hurry; they've got to get through! I used to sit all night with a patient in a home. I'd just lay down on the couch. The nurse would be there and I'd be there. We'd talk to them; we'd snooze a while, but we'd spend the whole night there if necessary. It's different now, and that's a difference between specialization and family doctors.

EPILOGUE

The age of medicine in which I was fortunate enough to practice—the 1930s through the 1960s—was the golden age of medicine. What changed it was the highly specialized men coming in, and all of the other new things—antibiotics, the new drugs for various diseases, the new and ultra-scientific diagnostic methods, all of the new laboratory work, all of the new surgical procedures that have been developed (the open heart surgery, transplant surgery, bone marrow transplant surgery, and the new drugs for malignancies)—all these things have changed the whole picture of medicine. Unfortunately, it is becoming so specialized that the doctor-family relationship is falling apart. Maybe it's for the better—I don't know. But my feeling is that we practiced in the golden age when you delivered the baby, you took the kid's tonsils out if he needed it, you did the appendectomy, you fixed their broken bones, you took care of them through the childhood diseases, you gave them their immunizations; and when they got to be adults, you delivered their children and you

took care of their children until they in turn had children of their own, which I have done many times. It just seemed to me a wonderful era of medicine.

After coming to Reno, I did general practice. I was a general physician, and I did my own surgery and my own obstetrics. Specialization was just becoming popular, and as time went on Reno developed a tremendous group of highly-trained specialists who were *really* tops in their fields. But they won't make any attempt at diagnosing or treating you for anything out of their own specific specialty. I think it raises the cost of medical care. You can't go to one doctor and have everything taken care of, like you used to in the old days. We would be taking care of a child with an abscessed ear, and in the next room there'd be a child with pneumonia, and maybe a father's in the hospital with an acute appendicitis. One doctor would be taking care of *all* those problems, and that isn't true anymore.

Specialists are now so highly trained that you cannot compare the work of one with that of a man who is doing general practice.

There are advantages for the patient, but the disadvantage is that often the specialist doesn't remember that there's a whole body involved, including the mind and the living conditions of the family and everything else. The specialist may see just his one tunnel-vision specialty and forget all of the rest of the body.

Specialization has also increased the financial burden to patients, because patients don't know where to turn. They start with a family physician, and then he has to refer them to a specialist, and if that doesn't happen to address the illness, then they have to go to another specialist, and pretty soon the financial burden can become a real family disaster. This is true partially because each specialist has highly sophisticated procedures that he wants to follow. He wants CAT scans, he wants MRIs, he wants stress cardiograms, he wants to catheterize the heart, he wants to do all of these things that are *really, really* expensive.

Surgery has certainly improved since those days in 1929. We have methods of getting rid of urinary tract stones and gallstones now without operations, and there are new operations coming out which will allow the removal of gallstones without surgically removing the gallbladder. We have also seen the advent of organ transplants; the first ones that I saw were kidney transplants, and since that time you see heart transplants, lung transplants and multi-organ transplants which are just phenomenal and require highly-specialized people. The treatment of coronary artery disease has changed now to where they do coronary artery by-passes; they do dilation of the coronary arteries with balloons; and they use medications now that dissolve the clots that form in arteries. So things have changed dramatically.

We are now also seeing genetic engineering used in research on various diseases, particularly the hereditary illnesses that are genetically linked. This research foretells a future in which we may be able to get away from children with Down's syndrome and with other hereditary diseases that they are born with, and with pulmonary problems that they are having.

Another improvement in medicine which has made a great impact is immunization, particularly for polio. We had epidemics of polio which were very dramatic, and now we rarely see a case of anterio-poliomyelitis. We used to have a lot of cerebrospinal meningitis, and we don't see that any more, I think primarily due to the development of antibiotics.

From the perspective of a general practitioner, I would put antibiotics as *the* most dramatic advance in medicine that I have seen. The family practice doctor, the general practitioner, the internist, the cardiac surgeon, the abdominal surgeon, the pelvic surgeon, the obstetrician, the ear-nose-and-throat specialist...*all* use antibiotics. Antibiotics are the most generally-used procedure that we have, and their introduction had an immediate and significant impact. They protected people against pneumonias, rheumatic fever, mastoids...and they allowed more aggressive surgery because with antibiotics the patient was protected from infection, especially in open burn surgery.

Of course, even with antibiotics you still must have aseptic procedures in the operating room, and they are more definitive now than they were ten years ago. We still use the same preventive procedures, such as cleansing the skin before making an incision and good cleansing before opening up a bone or going into the heart or anything else. That has not changed, and in fact antibiotics have really

not relegated many other practices to the past. The advent of antibiotics has certainly not replaced the general care of infections—it has shortened the length of time that people are sick with them, and probably has prevented many, many infections, but you still have to use the same care in the operating room or in the delivery room that you did before.

One of the places that antibiotics *have* replaced a lot of surgery is in the removal of children's tonsils and adenoids. We used to think that the removal of their tonsils and adenoids prevented children from getting rheumatic fever, particularly if they had many attacks of tonsillitis...and this was true. They would develop a streptococcal infection and would get rheumatic fever, which would involve the heart, the joints, the kidneys and the brain. Since the advent of antibiotics the need for tonsillectomies has diminished to almost nothing now. We take out *very* few tonsils and adenoids compared with forty or fifty years ago, when we were taking out almost every child's tonsils. Actually, even up until the last ten years, a tonsillectomy was a favorite operation. In retrospect, I think that we may have taken out too many tonsils, because the tonsils and adenoids are a protective mechanism for the body. By removing them, apparently we were laying patients open to other types of infections. But with antibiotics, the need for T & A (tonsil and adenoid removal) was reduced to practically nil.

The surgeon who only does minor surgery is a minor surgeon. [laughter] Everything that you do has its potential dangers—even down to giving an aspirin tablet. During my career the only thing that changed in regard to that situation is that today you *must* notify the patient that if he takes the prescribed medicine certain things might happen to him. The patient has to be informed about

everything. He has to be informed about anything that can go wrong in the hospital; he has to be informed about anything that can go wrong in the operating room; he has to be informed about anything that might happen to him due to the anaesthetic; he has to be informed about anything that might go wrong with him after the surgery. And unless you give him that information, you are remiss in your duty to him. The reason for that is because of all of the malpractice suits. It used to be that we told a patient, "We're going to take out your appendix—everything should be fine." And that's all we would have to say.

I have practiced for sixty years without a threat of a lawsuit or fear of a lawsuit, but I would order more x-rays and laboratory work today than I would have fifty years ago, even if I *knew* I didn't need them. In the 1930s, I would take care of a pneumonia in McGill at the patient's home without a chest x-ray, because I knew from the physical findings that the patient had pneumonia. Today I would be reluctant to make that diagnosis without an x-ray, which is another seventy-five bucks.

The threat of lawsuits would make me much more cautious about what I did for patients today than in those days; however, the actual treatment would not be affected, nor would I be reluctant to attempt any procedure. For example, I would treat a fracture the same way, but in repairing the broken arm I would explain to the patient that he might have a lump there from the callous or it might not be quite straight. I would tell patients all of the complications of taking out a gallbladder or putting a tube in their chest or doing a hysterectomy. I would have to sit down and give them all of the bad things as well as the possible good things. In the old days I wouldn't do that. We would just say, "You need this;" and the patient would say, "Let's go;" and this is the way we worked.

The increase in Caesarian sections was brought about by the fact that if you deliver a child with anything wrong with it that could possibly be tied to the delivery, you could be sued for it. In my early practice maybe 2 to 3 percent of our obstetrical cases were delivered by Caesarian section. Today almost 50 percent of babies are delivered that way, and it is because of the malpractice suits that come up. When I retired in 1978 I was still delivering most of mine vaginally—very few Caesarian sections. The only time we did Caesarian sections was when there was an absolute need of it. And now it is done more to protect the doctor from malpractice suits than to protect the patient's health. It's been bad the last twelve years, and the cost of *insurance* for doing obstetrics...!

Of course, it would be naive to suggest that there are no legitimate cases of malpractice or mistakes, and there are instances where I think people should be compensated for a medical mistake or malpractice, even though the thing was accidental and not a deliberate act by the doctor. We all make mistakes, and sometimes a patient should be compensated for that mistake in some way or another. But the thing has gotten way out of hand legally, because the amounts awarded by judges and juries are far and above the damage that's been done. This has led to the problem with doctors ordering many more tests and much more x-ray work and specialized investigative procedures than would be necessary if they didn't have that fear of a suit over their heads.

I know when a patient has pneumonia; I don't need a chest x-ray to tell me. I know when a patient has gallstones; I don't have to have a sonogram and an ultrasound and an MRI, which costs thousands of dollars—I can prove it with a very simple x-ray examination. But if you go in and you take out a gallbladder and you don't find stones, the patient says,

"Well, why did you take it out?" Then the lawyer is there to say, "Gee, that was an unnecessary surgical procedure, wasn't it, doctor?" And you have to admit, "Well, maybe it was."

A couple of years ago the doctors out in the rural areas of Nevada were not delivering enough babies to compensate them for the malpractice insurance it cost them, so they had to quit. I don't think many really wanted to give up delivering babies, because the basis of family practice is to deliver the baby and then take care of the baby up through infancy and childhood and adulthood. This is the fun of medicine: to know the family, to deliver them, to take care of them, to take out their appendix, fix their broken bones. But you can't do it today; it just isn't in the medical cards. Malpractice litigation and insurance have dealt doctors out of that way of practice.

Except for my wife Josephine, medicine has been the thing that I have lived for. I have tried never to hurt a person; I've tried never to overcharge patients; and I've tried never to embarrass one. Since retirement, looking back, I now think that I lived in the golden age of medical practice. It has now evolved into a highly scientific *business*.

When I was practicing, I thought that there was an art to medicine—that treating people required more than the science and the knowledge that we used. I thought that you should treat the patient's mind as well as the body; and I treated them as a friend, not just as a business acquaintance. Doctors should remember that patients are people, that they have feelings, and that you could just cut them down by a nasty remark or poor rapport with them. However, today doctors have lost the personal touch that good medicine requires. We laughed together and we cried together in the old days. When we lost a baby or lost a

patient, the doctor shed about as many tears as the family did, because he felt that he was losing part of his own family. And I don't think that exists today.

I know what medicine was when I practiced it. I don't think I would be as enthusiastic about entering the profession today, and I don't think I would be a general practitioner. I would probably go into radiology or something like that, where I worked eight hours, five days a week or less, and the hell with it after that! I wouldn't be called out all hours of the night; I wouldn't sit up with a sick patient for hours at a time; I wouldn't sit up with an obstetrical case all night; I wouldn't have all that personal worry. I think I would use it as a business, and I think that the place I would like to be is probably in radiology, just looking at x-ray machines or CAT-scanning or MRIs...things like that. I would go for the mechanical part of it and forget the patient, because I don't think that you can have a feeling for patients today. There are barriers between doctors and patients today that didn't exist fifty years ago. The thought of all the legal implications of a case today has to have a bearing on the doctor-patient relationship.

After I was married in White Pine County, we decided that Jo would join several organizations, which she did. We tried to make an impact on the community; we tried to have something to do with education, with the arts, with music, with speakers coming in, and this we did. And I think that as a group we doctors joined together and *did* make an impact and possibly made life a little better in White Pine County. Then when we came to Reno, we did the same thing. Especially in the early days, doctors and their wives as a group had a much more concentrated effect on the community than they do now with the

population explosion...and now the doctors and their families are not so cohesive as a group as in the past. They remain an influence in the community, but possibly not quite as much as they used to be.

A doctor should live a moral life and not be up for criticism by anybody. That filters down to his patients and to his patients' children—particularly those of a family doctor. In a small community the doctor is looked up to as a role model for people. The children look up to him, and if he lives a good moral life and sets an example, it filters down to those children. I've always felt that way; I've always acted that way, and I know that many, many other doctors do. That feeling was largely shared by my colleagues in the 1930s and 1940s. We were the family advisors. So many young women would come to our office for premarital advice. We would always give it to them with their fiance...sit down and just have a family talk about getting married and raising a family. I have done this hundreds of times with young people, and I think that it makes for better relationships with the family. I started to lose that role when I came into Reno, and then it got less and less until it finally disappeared.

Personally, I think that abortions should only be done to save the life of the mother or in the case of incest or rape. I think that other abortions should be illegal; there are better ways to handle the pregnancies than by abortion. We should teach these children the enormity of the thing that they're doing; we should teach them that prevention is better than the cure, and the best prevention is to abstain until you're married, and then have your family. Even then, if you don't want any children or if you only want a certain number, do family planning and regulate your sexual life to conform with what you want in the way of a family.

The debate on abortion has gone on since I was going to medical school in the 1920s. It has gotten more vehement and more active, and abortion *still* is not the answer. It is not a cure for the problem. The cure for the problem is a morality that prevents abortion, because otherwise you see the same kids coming back again and again for abortions. They're not a different group of children all the time; you find repeaters very frequently now, and I don't think that's the right way to handle it. We had women as patients who would come in with unwanted pregnancies, and we just told them that the only way we would handle it was to deliver the baby and let them give the baby up for adoption. There was always a family that would take these children who were not wanted or could not possibly be kept by the mother.

Since my early days in Nevada in 1929, 1930, 1931, I have been very much opposed to women with families working. Children in such families were never given very good training at home. The mother was working, the father was working, and the children ran loose in the neighborhood...and this was in a small town where they were taken care of by friends. Many of these women really didn't have to work, and when you would talk to them they'd say they'd rather be working than home taking care of the children.

I have been opposed to this all of my life. I don't mean the woman who is single or the woman who *has* to go to work, but I do oppose the woman who works to get away from her children. It has been one of the things that has torn down morals and families throughout the state. And so many times women have worked, and when they computed what they earned after they had two salaries, they weren't any better off than they were with just the husband working. I

would like to see the government give them enough to take care of them and keep them at home with their families. Of course, there are other factors, too, which maybe should be taken into consideration. One is that so many women developed hypochondriacal illnesses (which were a consequence of depression, as doctors later learned), and when they had outside interests such as a job, they would do better.

One of the things that I thought every female patient had a right to was a third party, another woman, present when she was examined pelvically, and I adhered to this throughout my career. It leads to a better feeling between the doctor, the patient, and the patient's family if someone else is present. That was just standard procedure when I was practicing in the 1930s and 1940s, but this has changed. Today's doctors don't have quite as much help in the office, and I think some doctors have no compunction about examining a female just like they would a male. It's all the same to them; it's just another patient.

In my opinion, alcoholism is not a disease; alcoholism is a *habit*. It's just like any other habit, like going to bed at ten o'clock at night or getting up at six o'clock to go to work, and *nobody* has ever been able to convince me that alcoholism was not a habit, or had any hereditary origins. It's no different than smoking tobacco or using drugs: they are all habits; they're all things that cause a lot of diseases, but they *per se*, are not a disease. As an individual, you either drink or you don't drink; you smoke a cigarette, or you don't smoke a cigarette; you smoke pot, or you don't smoke pot; you use heroin, or you don't use heroin. All of the ones that you use are habits, and that is all. They don't have a damn thing to do with your genes or diseases.

We came to Reno because Reno was a college town, but I can't say it is any more. The college is here, but it's not a college town. The university had *much* more impact on people then than it does at the present time. It had an impact socially and intellectually and many other ways. In 1953 the university was a gem in the setting of the city. Reno had several little manufacturing outfits, which have disappeared, and Stead Air Base was a government facility with a nice group of people associated with it. But the quality of life in Reno and Sparks has deteriorated with their growth. One of the reasons we came to Reno was that we had two daughters in high school and we thought a college town would be a nice place to raise them. I would think twice today before I brought them down here. We have seen a lot of changes in Reno. The contamination of the air and the consumption of alcohol may be the most noticeable. When we moved to Reno in 1953, the population was about thirty-six or thirty-seven thousand. I have watched the area grow, and with it the taking up of all the farmlands and occupying them with buildings and houses, and cutting down trees, and increasing automobiles; and watched the air change from a very clear, unseeable thing to a smoggy, dirty air, which at times is a danger to the people's health. I have seen an increase in pulmonary problems with this and an increase in upper respiratory diseases. Getting rid of the farmlands and the wetlands in this area have been a great detriment to it.

The growth of casinos, of course, has altered the social and economic environment. It's a shame to see a city like Reno dependent on gambling for its livelihood when it should be encouraging small businesses, manufacturing, warehouses, et cetera. I decry this spread of casinos and bars as poor ways of supporting a community. This mode of

life is not a good life. It does no good either psychologically or physically for the people.

Although the economic posture of the community is possibly better than it was when we came in 1953, I think socially we have gone down considerably. The casinos that we have built have made us bigger, but Reno is worse off for them. Part of the reason is that cheap help has been brought in to construct these casinos, but after the buildings are up there are no jobs for them, so they hang on until they either move or get on to some type of welfare program. And the gambling and the drinking associated with casinos bring in another class of people that are not desirable.

Compared to what it was in the early 1930s, and even as recently as the 1960s, the amorality of the state is pathetic. The number of teenage pregnancies, the amount of venereal disease that we have had for a long time, the development of AIDS in the state, and the increased use of narcotics, all develops a picture of the amorality of the community. Part of the cause is the phenomenon of the working mother. I think if we could just keep mothers home with their children, we might have a different scenario. And with all the increase in divorces, you have mothers bringing strange men home. What do you expect of the children? This is all they know—to satisfy your sexual desires; to satisfy your desire for a high; to satisfy your desire for alcohol. It all fits one picture, and I think we have to reevaluate all of our values today. We've let them go down the drain.

In White Pine County in the 1930s and 1940s I would leave my car parked in front of my house with the key in it and my medical bag in it in case I got a call at night. We never locked the door of our house; it was always open. In fact, I don't think I ever had a key to it. Even when we went on a vacation, the door was open so that the neighbor could take

care of the dog and take care of the flowers and the plants in the house. I noticed a great change when I came to Reno. People told me even at that time that I shouldn't leave my car out with the key in it, but for a long time it was perfectly safe to do that. And *now* I don't even go to the store without locking my car, which shows the difference in the attitudes of people *then* and *now*. And today I lock the house up even if I'm just going to the store. I don't leave anything open; I lock the windows and set the alarm system so that if anyone breaks in, the policemen come out. That is such a far cry from my first days in Nevada! With our growth, I don't think that we've gotten any better; we've gotten worse. It's a sad commentary on the growth of the state, and particularly our area.

I see a similar decline in the morals of the medical profession. Doctors are just people, and I don't think that they are different from any other group. I don't point the finger at one group; I point the finger at all of us. Doctors and their families are no different from ditch diggers and their families. I can put the practice of medicine on a pedestal, but I don't think I can put the medical practitioners on that same level. Doctors are human, and they have all of the good points and all of the bad points of anybody else. They do some funny things sometimes and some unethical things sometimes and some dangerous things sometimes, just like anybody else.

After retirement, I used to go to rural communities to relieve the doctors, because it was the only way they could get a long weekend. I should have done more of that, and it should be done more now. Rural doctors work seven days a week, twenty-four hours a day, and don't have any time off. Somebody should take it upon themselves to relieve these men occasionally and let them get away. I

don't know how many communities now have a single doctor, but if there are any, it would behoove the medical profession to see that they get relief.

To maintain and keep up with medicine today is a real full-time occupation. I always did some postgraduate work every year—going to educational meetings or going to regular classes—and up until the last ten or fifteen years, you could keep up pretty well. Now there are so many new things coming out that one just can't keep up with everything, but he must at least keep up with the things that he is involved with in his practice. This can be done easily by attending various meetings and classes, but it may be more difficult for a general practitioner than for a specialist. With a specialty you can go to a two-week course once a year and really be current in what is done. But a general practitioner with a family practice has to take in more because he has to handle so many more things. The requirements on his intellect are more pressing. To be a good GP you have to know the new things that are coming out in every field, and that requires a lot of hours. I would say that one should spend at *least* a hundred hours a year in study, not by himself but in groups. That's a minimum of two-and-a-half to three weeks a year.

All the doctors felt that I was a pretty good diagnostician. I don't know; maybe I was. I just seemed to be able to ferret out problems that were obvious to me that weren't to other people, perhaps because I had to do so many different things in White Pine County, where we were eight hours away from the nearest help. There we learned to do almost everything and to take care of any emergency.

Looking back over sixty years of medicine, I can't recall any *specific* case of mine that was

a great doing. Each case was a challenge, and each case was a triumph when they got well. I was fortunate in being a fairly good diagnostician so that I knew pretty much what was going on with a patient, and I never was reluctant to call in a consultant when I thought they would do a better job than I would do. God knows I bothered the other men lots and lots of times. But medicine is just a panorama of things that you're doing all the time, and no one case stands out in my mind above all others. People will say, "Oh, you saved my life, doctor; you saved my baby's life." That isn't true. We might have helped, but I think the good Lord saves them; we don't. Along with the successful cases, of course, every doctor who practices and sees a lot of patients sees the sad part of medicine—the times when you deliver a dead baby; the times when a child dies in an anaesthetic death; when a pregnant mother dies for one reason or another. And you learn to cry with them as well as to be happy with them.

I have seen many things in my sixty years of medicine that I think were miracles, but there is one I would like to make particular note of. I had delivered a baby at St. Mary's Hospital with a nurse giving the anaesthetic and a Sister who was a nurse circulating in the delivery room. When the baby was born it had no heart beat and was not breathing. I proceeded to use the usual methods of resuscitation, such as a suction of amniotic fluid out of the lungs, and started artificial respiration and cardio-respiratory resuscitation methods that we used at that time, and lo and behold, the child's heart began beating and the child began to breathe. The Sister who was standing there said, "I don't know whether I've ever seen one before, but this was a miracle." The child grew up to

be a very delightful young lady who is now married and has three children of her own.

It has always been my belief that there is a superior being, God (call it Him or Her or what you want), and in my whole life and medical experience, I have felt *definitely* that this being watches over us and helps sick patients come out of a condition that seems absolutely impossible. Yet, again, I have seen patients die whom I thought would be well for years to come. But I still feel in my heart that there is a God and he watches over all of us. Occasionally, when I was with patients in the operating room or when I was treating patients, I am positive that I have been guided by something that I can't explain.

Medicine has been a godsend to me. It's given me the opportunity to help a good number of people, I *hope*, and it's been a very satisfying profession. I don't know what I would rather have done than be a doctor.

PHOTOGRAPHS



Noah Smernoff, 1928

Photograph courtesy of Noah Smernoff



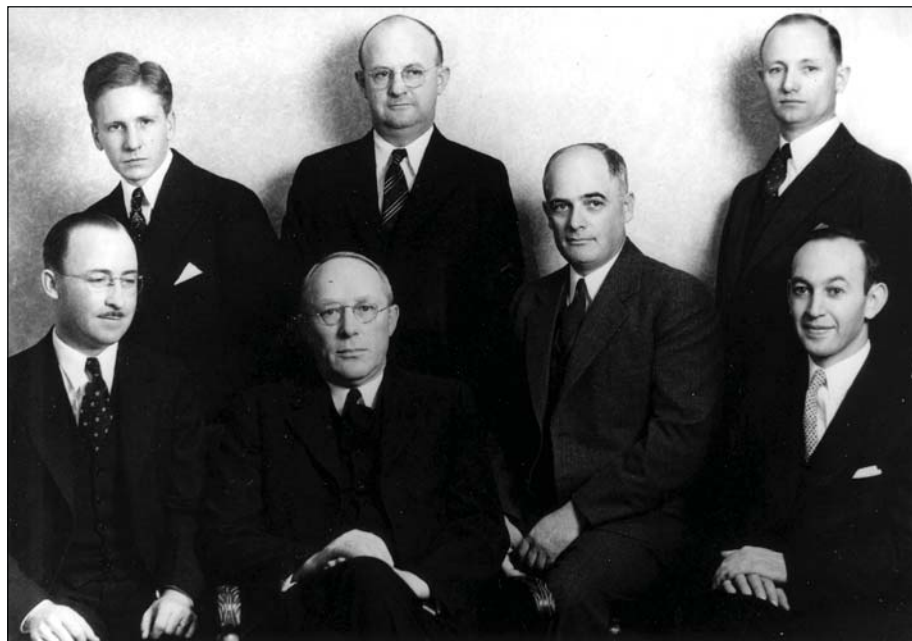
An early photo of Upper Town in McGill, much as it appeared when Dr. Smernoff arrived in 1929.

Courtesy of Special Collections, University of Nevada, Reno Library



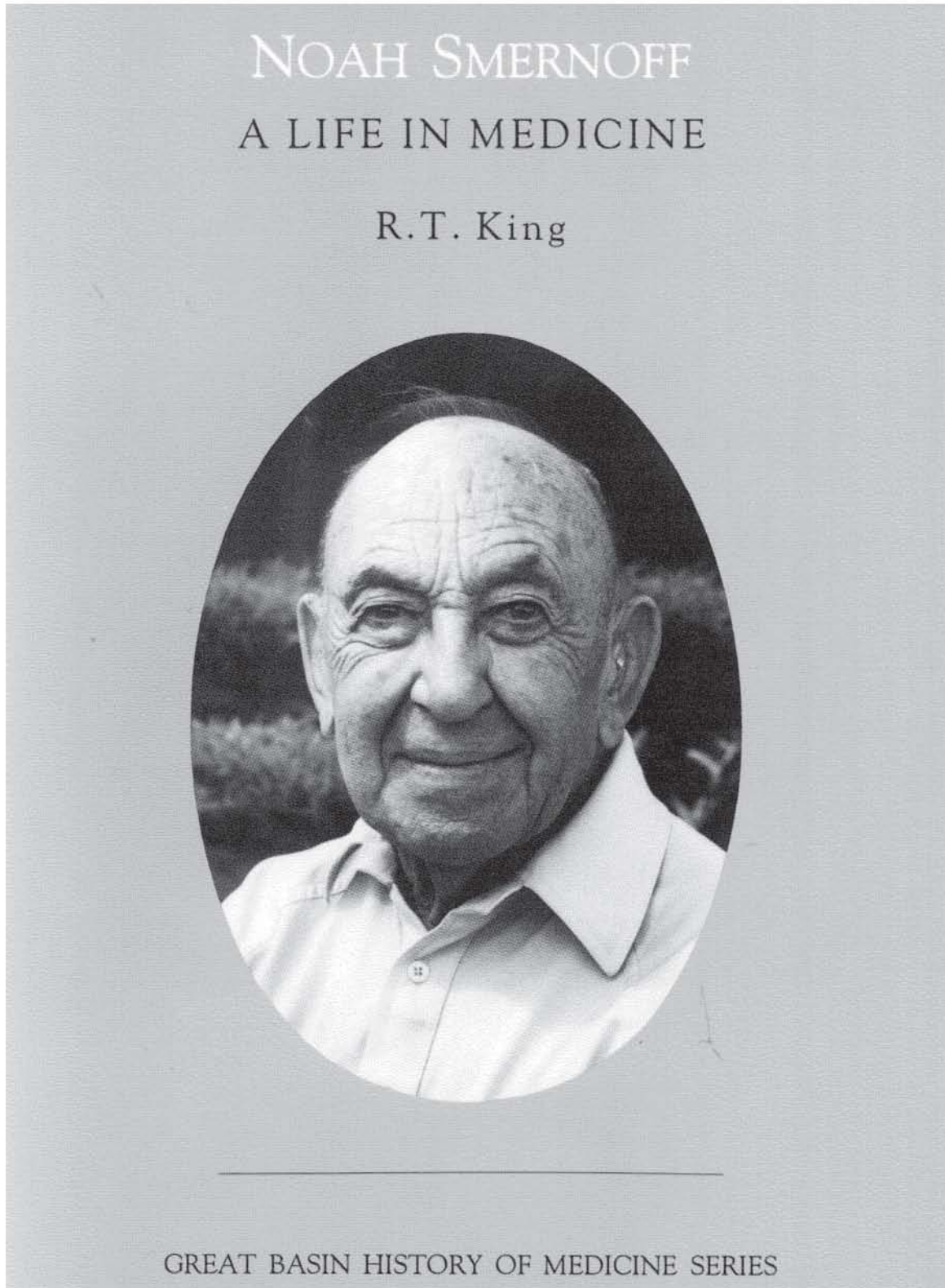
Josephine Smernoff, nee Elbert, in 1929

Photograph courtesy of Noah Smernoff



The medical staff at Kennecott Copper Corporation in the Ely district, ca. 1934. Front row, left to right: E. B. Muir, R. A. Bowdle, W. H. Frolich, Noah Smernoff. Back row, left to right: H. B. Elkins, O. Hovenden, W. B. Ririe.

Photograph courtesy of Noah Smernoff



Original Dust Jacket (cover)

Noah Smernoff: A Life in Medicine

R.T. King

NOAH SMERNOFF BEGAN practicing medicine in 1929. His career spanned half a century, and took him through some revolutionary changes in his profession and in the human societies that he served. A county hospital internship, industrial medicine in a company town, advances in pharmacology and medical technology, the changing doctor-patient relationship... all are chronicled in *Noah Smernoff: A Life in Medicine*.

While in high school, the young Smernoff decided that he did not want to end up as "some kind of day laborer," so he worked to become a top chemistry student at the University of Denver, and in 1924 he gained admission to the University of Colorado School of Medicine. Upon graduating in 1928, Dr. Smernoff took a year-long internship at Salt Lake County Hospital: "By interning in a county hospital, I found out early in my career that poor people hurt as much as rich people, and I made up my mind that whenever I took a patient they would get the same care, no matter what their color or creed or their financial situation. I have kept to that my whole life."

During his internship, Smernoff was introduced to industrial medicine when he did a month-long stint pinch-hitting as a surgeon at the Bingham Canyon Hospital, which served five underground mines. This experience was instrumental in determining the career path he was to follow. In 1929 he accepted a position as a company physician for Nevada Consolidated Copper (later a subsidiary of Kennecott) in the company town of

Original Dust Jacket (inside flap)

McGill, Nevada. He recalls the long, hard hours: "We [doctors] did not exactly share the shifts equally at the McGill emergency hospital. It worked out this way: the young man usually took twenty-four hours, six days a week. And I was the young man." Dr. Smernoff also describes the benevolent paternalism and rigid social stratification of life in a company town where the labor force was largely drawn from immigrants and ethnic minorities. In 1943, Dr. Smernoff was promoted to assistant chief surgeon in the company's large Steptoe Valley Hospital in nearby Ely. In 1953 he left Kennecott and set up a practice in Reno, immediately becoming an important participant in the efforts to cope with the great polio epidemic, which had not yet run its course. The following year, he and a partner founded a clinic of general practitioners that grew to become the large and very active Ralston Street Clinic.

Dr. Smernoff felt that he was fortunate to practice during what he characterized as the golden age of medicine, when the physician treated the whole body, including providing counseling to individuals and families: "When I was practicing, I thought that there was an art to medicine—that treating people required more than the science and knowledge that we used. I thought that you should treat the patient's mind as well as the body; and I treated them as friends, not just as business acquaintances.... We laughed together and we cried together in the old days. When we lost a baby or lost a patient, the doctor shed about as many tears as the family did, because he felt that he was losing part of his own family. And I don't think that exists today."

Jacket Design: Helen M. Blue

THE UNIVERSITY OF NEVADA ORAL HISTORY PROGRAM (UNOHP)

A statewide program of the University of Nevada, Reno, UNOHP seeks to record primary source oral history interviews that address elements of the history and culture of the American West, concentrating principally on Nevada and the Great Basin. Subjects such as mining, ranching, urbanization, water rights, medicine and health care, prostitution, casino gambling, politics and government, and the experience of ethnic groups in the development of the West figure prominently in its efforts.

Since its founding in 1965, UNOHP has completed over two hundred oral history interviews from which forty thousand pages of transcription have been generated. Sets of these oral histories and copies of all other UNOHP publications are held by the University of Nevada Libraries in Reno and Las Vegas. Additionally, the entire collection has been copied on microfiche, and complete sets in this format have been acquired by major public access repositories throughout the state. For copies of the UNOHP's oral histories, its catalog, master index, or any of its other publications write to:

University of Nevada Oral History Program/324
Reno, NV 89557
Telephone: 702/784-6932



THE GREAT BASIN HISTORY OF MEDICINE DIVISION

In 1989 the University of Nevada School of Medicine's pathology department established the Great Basin History of Medicine (GBHM) division to research and preserve the history of health sciences in our state. As one part of that effort, GBHM enlisted the university's Oral History Program in a collaborative project to record the experiences of physicians and others whose careers are important to understanding the development of medicine in Nevada. Realizing that health care workers who practiced in the state during the first half of the twentieth century are a limited and dwindling resource, the initial focus has been on doctors who practiced prior to World War II. On a larger scale the goal is to describe comprehensively the daily life of health care practitioners and care of patients, from early times to the present. *Noah Smernoff: A Life in Medicine* is the initial volume in this series.

University of Nevada School of Medicine
Department of Pathology/350
Reno, NV 89557

ORIGINAL INDEX: FOR REFERENCE ONLY

In order to standardize the design of all UNOHP transcripts for the online database, they have been reformatted, a process that was completed in early 2012. This document may therefore differ in appearance and pagination from earlier printed versions. Rather than compile entirely new indexes for each volume, the UNOHP has made each transcript fully searchable electronically. If a previous version of this volume existed, its original index has been appended to this document for reference only. A link to the entire catalog can be found online at <http://oralhistory.unr.edu/>.

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